

**MODERNIZING HEALTH CARE:
HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS**

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

OCTOBER 22, 2025

Serial No. 119-16

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Wednesday, October 22, 2025

U.S. SENATE
SPECIAL COMMITTEE ON AGING
Washington, DC.

The Committee met, pursuant to notice, at 3:27 p.m., Room 216, Hart Senate Office Building, Hon. Rick Scott, Chairman of the Committee, presiding.

Present: Senator Scott, McCormick, Justice, Tuberville, Johnson, Moody, Husted, Gillibrand, Warren, Kelly, and Warnock.

Also present: Senator Marshall.

**OPENING STATEMENT OF SENATOR
RICK SCOTT, CHAIRMAN**

The CHAIRMAN. The Senate Special Committee on Aging will now come to order. Free market capitalism has helped make the United States the envy of the world. It helps spur innovation, keep costs down, and give consumers options, empowering them to shop around and find what works best for them. When you shop around, you think about price, quality, and value, and the free market allows you to find the option that suits your needs and your budget.

For too long, Americans have been robbed of the ability to make informed choices in healthcare because they don't have the information they need. Our country has allowed the U.S. healthcare system to operate in the shadows without price, transparency, or true consumer choice. The result is a complicated system of inflated "Is this the best doctor for my needs?" We ask, is this doctor in my network?

Instead of asking if the cost of the surgery or medicine could be more affordable or better quality elsewhere, we ask how much is the copay? Trying to navigate the bureaucracy to get answers to healthcare costs and pricing can be incredibly intimidating, especially for vulnerable populations like many in our aging community with healthcare emergencies happen and we don't always have time to research and shop around for our best option, but for a huge section of our healthcare needs, there is clearly a better way to operate for everyone from patients to doctors.

What I'm talking about is known as shoppable services and they include elective surgeries, lab tests, prescription drugs, and more. These kinds of healthcare services make up roughly 40 percent of all healthcare costs and there is significant potential to introduce

consumer-driven, free market reforms like price and transparency into this space to help drive down healthcare costs for all Americans, including our aging population.

We know some sites and pharmacies charge more than others for these exact same shoppable services. For example, hospitals charge more than ambulatory surgical centers. In Medicare, we try to address this problem through site neutral payment reform, but in the commercial insurance space, things get more complex. That's because in the current commercial marketplace, it's up to every insurer to reach a cost arrangement.

With healthcare providers, those agreements have different reimbursement rates and those differences get passed on to consumers at different rates. Because of these agreements, the cost differences are not always tied to quality, meaning two patients could be receiving the same treatment, but one could be paying significantly more because of the cost agreement made behind closed doors and they can actually get a completely different quality and different service not tied to price at all.

For example, MRIs or essentially fancy command cameras that take lifesaving pictures. You have a digital camera, you have a phone, how much your neck picture costs, yet there's a wide disparity in pricing and cost passed on to the patient depending on their insurance provider. Lab tests, they're the same. The cost of the test can vary widely by providers, but you're receiving the same quality lab result no matter what you or your insurance provider is paying for generic drugs, which is up to 90 percent of the drugs dispensed.

At Affirmity Pharmacy, there typically isn't upfront price transparency for conservative price shop. That makes no sense, and I typically quote more specific price examples, but providers don't like to publicly list their prices and rely on hiding the actual cost of services they're providing. Not only does this secrecy make it difficult for consumers to make smart market driven choices, it allows prices to inflate and drives up cost for everyone.

Price transparent transparency is not a partisan concept. It's common sense. When patients can see prices, they can make informed choices. When providers compete on price, quality and costs go down price, when they compete on price and quality costs go down because we don't operate this way right now, there's too much inflated pricing in the healthcare system, and that's true whether you're in New York or whether you're in Florida.

The current system simply does not incentivize people to seek lower cost options. Healthcare doesn't have to be any more complicated than a lot of other things. I spent most of my life in business and I've run one of the largest healthcare companies in the world. I learned pretty quickly that when you make things simple, give people price, transparency and focus on outcomes and quality, the result is lower costs, healthier patients, and a better system for everybody.

Today, we have the opportunity to hear from witnesses who have put what I've said into action and look forward to hearing how they are working to provide service for our aging population and all Americans. I'm also eager to hear their thoughts on how we can

work to empower patients to make decisions and reduce some of the inflated costs in our healthcare system.

Hope today's hearing will be the start of the discussion on how price transparency and competition can drive down costs, improve quality for all Americans, but especially our agent population. Now, I welcome my ranking member, Senator from New York, Senator Gillibrand, for her opening statement.

**OPENING STATEMENT OF SENATOR
KIRSTEN E. GILLIBRAND, RANKING MEMBER**

Senator GILLIBRAND. Thank you, Chairman Scott, and thank you for calling today's hearing. Thank you to all our witnesses. This is going to be an excellent hearing. Everyone in this room today is here because we all agree that the cost of healthcare is too high in the richest country in the world.

It is unacceptable that one in three adults skip or postpone getting healthcare that they need because of the cost. It's unconscionable that one in three adults do not take their medication as prescribed because of costs. This afternoon, we will hear from a wide range of witnesses who will share their expertise on how Americans' ability to shop for health plans, medical services, and drugs can help them access the care they need at a cost they can afford.

Every year during open enrollment, tens of millions of Americans visit the Health Insurance Marketplace to shop for a plan that works for their family. They're able to see if plans include the doctors that they need or the medications that they need and weigh the differences between them based on premium costs, deductible amounts, and other factors that matter their households. It's the ultimate shoppable service.

Unfortunately, at the end of this year, crucial tax credits that help hardworking families afford the Marketplace health plans are going to expire. On average, these families will have to pay more than twice as much for their premiums in 2026, and many enrollees will have to pay more. It's a cost they definitely can't afford.

Nearly five million Americans will likely lose their healthcare coverage and become uninsured. These enhanced tax credits particularly help many of the five million adults between the ages of 50 and 64 who buy their insurance through the Marketplace. These enrollees are people who've had to scale back hours at their job to care for aging parents, people forced to work part-time until they retire because of a physically demanding career, or people who retire early and can't get private insurance because of preexisting conditions.

Over half of the people said to lose tax credit eligibility altogether are within this age range, many within an income level just above the eligibility cutoff for the standard tax credit. By January, they could pay tens of thousands more in premium costs. That's a lot of money out of your pocket when you're trying to save for your retirement.

In nearly every state, because of age rating, older adults can already pay nearly three times as much as younger adults do for the same plan. Losing tax credit eligibility will compound those higher costs. These older enrollees also have greater healthcare needs. Even if their premium costs increase dramatically, they're more

likely to keep their bank-breaking coverage and be forced to make difficult choices between basic necessities, whether it's food or rent. Older adults who ultimately lose their coverage may avoid seeking care until their needs become an emergency and will then enter the Medicare program at 65 in poor health and ultimately require more cost-intensive care.

I've heard from a lot of constituents across the state about the positive impacts these enhanced premium tax credits have had on their ability to live with dignity, and potentially have to make those devastating choices that will make it very difficult to survive. One constituent asked, "Do I pay for my healthcare coverage and be healthy, or pay for the food that I feed for my family? This is what it comes down to. I'm always going to choose my family."

"So now, if I go to a doctor for my debilitating migraines, or my diabetes, or emergency care, I'll have to pay more out of pocket because I can't afford the premiums," another constituent shared. "I depend on my health insurance for daily medication, frequent appointments, and procedures. I'm a New Yorker who has worked full-time since I was 19 and still can't get ahead in life. I can't afford to see doctors without insurance, and my employer plan is unaffordable. What am I supposed to do?"

These enhanced premium tax credits have been a key driver of the record 24.3 million Americans being signed up for coverage in the Marketplace. They play a vital role in bringing down the cost of accessing high-quality care. For many enrollees, the cost of care is still incredibly high, and this is not the entire solution, but it will address an urgent affordability crisis that's happening right here, right now.

For example, people in Idaho have already started signing up for coverage, and in less than 10 days, people across all the other states will too. If Congress doesn't act to extend these credits before enrollment begins, Americans will experience sticker shock at the rate hikes and may decide to drop coverage with only a very slim possibility of them ever being able to come back.

I stand ready to work with my colleagues on this to reach a bipartisan deal and extend the critical tax credits that will allow consumers to shop for healthcare plans that cover the cost of medical services, and drugs and what they need to get for their healthcare.

I look forward to the discussion about how to lower costs. I know you all have some really great ideas that I want to hear about, and I'm excited that this committee is working on how can we best lower costs. Thank you.

The CHAIRMAN. Thank you. Now, I'd like to welcome our witnesses, all of whom are at the forefront of challenging the status quo in today's healthcare system.

First, I'd like to recognize Mark Cuban our second Shark. This year Mr. Cuban is the co-founder of Cost Plus Drugs company, an innovative online pharmacy that's changing how Americans purchase their medications.

At his company, he lists the medications actual costs as a 15 percent transparency markup and sells directly to consumers. For millions of Americans struggling with high prescription costs, especially seniors on fixed incomes, this model has shown that transparency and competition can deliver real savings.

Thank you for being here. You may begin your testimony.

**STATEMENT OF MR. MARK CUBAN, CO-FOUNDER,
ENTREPRENEUR, COST PLUS DRUGS, DALLAS, TEXAS**

Mr. CUBAN. My Shark Tank companies hate selling on Amazon, but most don't have a choice. About 162 million Americans shop there, and if you want to reach them, you have to play by Amazon's rules. Amazon knows this and takes full advantage adding, and raising fees, and even launching competitive knockoffs. They get away with it because they control the marketplace, and because 162 million people shop there, which makes Amazon incredibly sticky.

What does that have to do with healthcare? Insurance companies work the same way. Over 300 million Americans have some kind of coverage, commercial, ACA, Medicare, or Medicaid. Every one of those plans hires a pharmacy benefit manager, or PBM, to run their drug benefits. The biggest PBMs all owned by the largest insurance companies, control pharmacy benefits for about 270 million Americans. That's a lot of power, and that's also 70 percent more people than Amazon reaches.

Like Amazon, PBMs control the store shelves, but their shelves are called formularies; the list of drugs your insurance will cover. If a drug isn't on the formulary, it's invisible to doctors and patients.

Here's the kicker. Unlike Amazon, which wants lower prices, PBMs actually prefer higher prices. They say they negotiate lower drug costs, but they don't. They auction off access to their formularies to the highest bidders. Drug companies pay their rebates and fees. PBMs demand so their drugs can be covered and prescribed. If they don't pay, they lose access to millions of patients and plenty of doctors costing them billions.

These rebates and fees are based on a percentage of a drug's list price called WAC, the wholesale acquisition cost. The higher the list price, the more money PBMs make. Because PBMs are so powerful, that inflated list price becomes the reference point for the entire drug supply chain.

Take a hypothetical \$600 brand name drug. The PBM strongly suggests the manufacturer set the price at \$600 with a 50 percent rebate, and another 10 percent in fees, leaving the manufacturer with \$240 net. Meanwhile, wholesalers buy the drug at that same \$600 list price. How many industries do you know where the wholesalers pay the full list price?

The three major wholesalers all use the same list price and get paid almost identical fees. There's zero competition, and their fees are also because they're tied to list price. They make more money when prices rise. Pharmacies buy from wholesalers at about a five percent discount. You think PBMs would reimburse them more than their costs so they can make a profit? They don't.

When a pharmacy fills a brand prescription for an insured patient, it's often reimbursed less than what it paid for it. If it doesn't fill enough of those money-losing prescriptions, PBMs or wholesalers can penalize them. It's no wonder independent pharmacies are disappearing.

Now, what does the patient pay? If they're uninsured, they pay that \$600 list price. If they're insured but haven't met their deductible, they still pay the full \$600. That's crazy. We were told that PBMs negotiate lower prices for patients, but they're so bad at their jobs, they can't even get patients a deal that's better than the retail price. The rebates and fees that they collect on that \$600, flows straight from the patient's pocket to theirs.

Patients are getting ripped off because PBMs and wholesalers insist on using inflated list prices instead of transparent net prices. Because the whole system is built around list prices, everyone, PBMs, wholesalers and insurers have an incentive to keep prices rising and they almost always do. It's costing patients' tens of billions of dollars and forcing many to go without the medications they need.

Here's the saddest part. Self-insured employers, states, the Federal Government, they all keep on signing contracts that lock in this broken system. We blame PBMs, but the real problem is the CEOs, administrators, and state officials who keep renewing these contracts. Every one of them complains about rising healthcare costs while signing deals that make prices go up.

Big-brand Pharma is part of the problem, too. They hate PBMs, but still play along. If manufacturers, wholesalers, and payers, moved to net pricing, meaning the price after all rebate and fees, patients' out-of-pocket costs could drop by half overnight, saving patients billions every year.

There's a reason the U.S. has the highest drug prices in the world. We're the only country that uses PBMs. There's a reason we have some of the lowest price generics; PBMs can't control generic pricing from companies like Cost Plus Drugs. What do we do? One, count all cash payments toward deductibles. Two, based patient out-of-pocket costs on net price, not list price. Three, separate formularies from PBMs to end their power, and four, specialty tier, it's just an excuse to charge more.

Fix that, and we finally put patients, not PBMs, back at the center of American healthcare. Thank you.

The CHAIRMAN. Thank you. Next, I'd like to introduce Dr. Keith Smith, co-founder of the Surgery Center of Oklahoma, and the Free Market Medical Association. Dr. Smith is a nationally recognized leader in healthcare transparency and free market reform.

More than 25 years ago, he helped establish the Surgery Center of Oklahoma, one of the first facilities in the Nation to post all-inclusive upfront prices for every single surgical procedure covering the surgeon, facility, and anesthesia, all in one transparent bundle. His center consistently delivers care at a fraction of the cost of traditional hospital settings, while maintaining exceptional outcomes and patient satisfaction.

In addition to his clinical work, Dr. Smith co-founded the Free Market Medical Association, which brings together physicians, employers, and patients to promote transparent, market-driven solutions in healthcare. His leadership has inspired similar models across the country, proving that when providers compete on price and quality, patients win.

Dr. Smith, thank you for being here today. Please begin your testimony.

**STATEMENT OF DR. G. KEITH SMITH, MD, CO-FOUNDER,
SURGERY CENTER OF OKLAHOMA, AND THE FREE MARKET
MEDICAL ASSOCIATION, OKLAHOMA CITY, OKLAHOMA**

Dr. SMITH. The Surgery Center of Oklahoma was founded in May 1997. The goal was to gain control of the medical and financial treatment of our patients. The problem was that even a minor surgical procedure performed at a large hospital meant bankruptcy for many patients, including insured patients.

Consistent with their attempts to maximize revenue, big hospitals denied physicians many times the tools and supplies they thought appropriate to treat patients, and yet, hospitals continue to book ever-increasing profits even today.

I've changed this model. Our model is grounded on mutually beneficial exchange. While we save patients tens of thousands of dollars currently the only ones walking through our door, patients paying for their own care are about half the population. Because if someone else is paying, they don't shop or care how expensive something is.

We were excluded from insurance from the very start, which meant that we had to be creative. We started quoting patients' all-inclusive prices. It was simple math. What fee did the surgeon think was fair? What was fair for anesthesia, and what was the time and materials-based charge for the facility? It turns out that our prices were usually less than the patients in-network deductible and copay.

Today, our total charges are still only one-sixth to one-tenth of what large hospital systems near us charge for the same procedure, and even more extreme price discrepancies are routine. In fact, we recently performed a tonsillectomy on a child for \$3,875 after the family had been quoted \$72,000 by a Dallas area hospital. Our prices remain half what Medicare pays big hospitals and less than what Medicaid payments are to the hospitals for the very same procedure.

The Surgery Center of Oklahoma quoted prices over the phone to patients until 2009, which is when I launched the first website displaying all-inclusive surgical prices. I had three goals in mind, all of which I would argue have been achieved. First, I wanted sticker-shocked patients to easily find us. Second, I wanted to start a price war so patients far from Oklahoma could use our pricing as leverage in their local market. Third, I wanted to better understand why the same market discipline other industries must endure was seemingly not a thing in healthcare.

The first patients to arrive after posting our prices were Canadians. These patients are forced to wait in lines longer than the misery they can endure without care. Then, it was the uninsured beneficiaries of self-funded health plans, and members of cost sharing ministries. Approximately, half our patients travel from out of state or out of the country to Oklahoma City for their surgical care.

As news of the success of our model has grown, so has the number of facilities, and I'm happy to report large hospitals who have now copied us price matching in the industry has had a deflationary effect even on the price gouging facilities as they stand to lose business and patients if they don't compete.

Our model also increases the quality of care because physicians with unpredictable outcomes shy away from this tightly disciplined space. The good surgeons would rather perform a surgery at my facility due to better conditions and the higher pay they actually receive while building the surgery center and changing the market.

My mission is now grown. I now also run Atlas Billing Company, which facilitates payment bundles for the Surgery Center of Oklahoma, and is now curating and implementing surgical bundles for many other facilities now attempting to accommodate price-sensitive buyers and patients.

I'm also co-founder of the Free Market Medical Association, a mission-driven organization that works to bring buyers and sellers together in the United States, promotes market discipline in the industry, and now has 37 state chapters.

To the industry big shots, or as I call them, the cartel, the healthcare system in this country isn't broken. It's working exactly as it was designed, meant to enrich the corporate elite and intermediaries at the expense of patients and the American people at large.

Fortunately, the alternative approach I've described is becoming more widespread as insurance deductibles balloon, and delays and denials become more commonplace. Affordable, high-quality care is fortunately available for victims of the system. I predict that shoppable medical services will become particularly critical for older Americans as an increasing number of physicians opt out of or severely curtail their exposure to Medicare. Thank you.

The CHAIRMAN. Thank you, Dr. Smith. Now, I'd like to introduce Dr. Don Moulds, the Chief Health Director for the California Public Employees Retirement System, CalPERS. Dr. Moulds oversees one of the largest public health purchasers in the United States, governing more than 1.5 million public employees, retirees, and their families.

Under his leadership, CalPERS pioneered the use of reference-based pricing, where they set clear benchmarks for elective procedures like joint replacements that allowed patients to shop for care that meets both cost and quality standards. Dr. Moulds brings valuable insight into how large purchasers can use data and competition to make healthcare markets work the way every other market due to the benefit of the consumer.

Thank you for being here. Please begin your testimony.

**STATEMENT OF DR. DON MOULDS, PH.D., CHIEF
HEALTH DIRECTOR, CALPERS, SACRAMENTO, CALIFORNIA**

Dr. MOULDS. Chairman Scott, Ranking Member Gillibrand, members of the committee, thank you for inviting me to testify on behalf of the California Public Employees Retirement System. My name is Don Maltz and I serve as Chief Health Director for CalPERS with more than 1.5 million members.

CalPERS is the largest commercial health benefits purchaser in California, and the second largest commercial purchaser in the Nation. We contract with numerous large health insurance companies to provide our members with a variety of health plan offerings. In 2024, we spent about \$12.5 billion dollars to purchase health benefits for active and retired members and their families.

CalPERS employs a range of innovative cost containment strategies to address rising medical costs. Among these is reference-based pricing, which is proven to be an effective tool for addressing shoppable services that tend to vary greatly in price.

In 2011, CalPERS implemented a reference pricing program for hip and knee replacements, which are good examples of services with significant cost variation across facilities. Through this program, 46 California hospitals that met quality standards agreed to a fixed price of \$30,000 for these surgeries. Members who chose reference price facilities paid standard co-insurance, while those who opted for non-participating facilities were responsible for any costs above the reference price. In addition to their standard co-insurance, within two years, the program increased the portion of members that used the preferred facilities from about 50 percent to 64 percent.

What was particularly noteworthy was that the non-referenced price facilities reduced their charges to meet the CalPERS reference price. As a result, price variation decreased dramatically. The average price dropped from \$35,000 to \$25,000, while the non-referenced price facilities dropped their prices from \$43,000 to about \$27,000.

While we anticipated savings from the consumer choice effect, the most significant impact was the downward pressure on the market. Overall, the program remains in place today, and our analysis reveals sustained savings of approximately four million annually through 2020.

In 2012, CalPERS introduced a second reference pricing program for colonoscopy, cataract, and arthroscopy services, establishing a set reference price for procedures performed in hospital outpatient settings to incent members to choose ambulatory surgery centers, which are comparatively less expensive and higher quality.

As with hip and knee replacements, we saw members choose the more cost-effective sites of care, resulting in five million in savings per year. An average reduction of 21 percent for these procedures. CalPERS extended its ambulatory surgery center-referenced pricing program to 12 additional procedures in 2018.

Last year, CalPERS implemented a member incentive program to encourage members to use independent labs instead of much more costly hospital-owned labs. Early data suggests that preferred lab use increased by modest four percent in that first year and saved our members \$2.4 million in the first year.

This program is different from earlier reference pricing programs in that it eliminates cost sharing for members using the low-cost labs, but does not increase their cost sharing for using higher price labs.

Reference-based pricing has shown promise, but it does have its limits for smaller purchasers. Without the data resources of CalPERS, access to transparent pricing information is critical. Moreover, research suggests that if implemented as broadly as possible, reference pricing only saves about five percent of total cost of care.

Overall savings are limited by the small number of procedures where reference pricing makes sense. While reference pricing is well-suited for non-emergent elective procedures with significant

price differences, many healthcare services are far less shoppable. This is one of the reasons why CalPERS adopts a broad-based approach for reducing costs. For example, we have included cost trend guarantees in our newest contracts with our third-party administrators and our pharmacy benefits manager in order to achieve critical financial alignment.

Addressing high-cost markets is also a priority. CalPERS pays prices that are about one-third higher in Northern California than it does in Southern California, largely because of a comparative lack of provider competition in the north.

Thank you again for inviting me to participate in today's hearing. CalPERS is proud of the savings we've achieved through our reference pricing programs, which is one part of the kind of broad-based approach that is necessary to reign in healthcare costs.

I welcome your questions.

The CHAIRMAN. Thanks for being here. Now, I'd like to turn it over to Ranking Member Gillibrand to introduce your witness.

Senator GILLIBRAND. Thank you, Chairman Scott. I want to move to introduce our final witness, Dr. Jeanne Lambrew. Dr. Lambrew is the Director of Healthcare Reform and senior fellow at The Century Foundation, previously having served in President Obama's Administration, first as director of the Office of Health Reform at the U.S. Department of Health and Human Services, where she worked to ensure passage of the Affordable Care Act.

Dr. Lambrew served as President Obama's Deputy Assistant for Health Policy, where she helped to guide the implementation of the Affordable Care Act. Most recently, Dr. Lambrew served as the Commissioner of Maine's Department of Health and Human Services following her appointment by Governor Janet Mills.

Thank you for being here, and you may begin your testimony.

**STATEMENT OF DR. JEANNE LAMBREW, PH.D., DIRECTOR
OF HEALTH CARE REFORM, AND SENIOR FELLOW, THE
CENTURY FOUNDATION, NEW YORK, NEW YORK**

Dr. LAMBREW. Chairman Scott, Ranking Member Gillibrand, and members of the committee, thank you for the opportunity to testify today.

As you've heard from other witnesses, competition, streamlining, and shopping can optimize value. However, the nature of illness, and injury, and their costs, means that most people can't finance healthcare on their own. This is why every industrialized nation has some sort of health insurance system. As such, I'll discuss shopping and transparency for health plans rather than health services, with a focus on older Americans purchasing coverage on their own.

The Affordable Care Act created a shopping platform called Health Insurance Marketplaces. Marketplaces offer health plans that have different levels of coverage. Shoppers can see if their doctors or drugs are covered, and some marketplaces are active purchasers requiring insurers to use some of the strategies discussed here today.

This shopping experience is enhanced by premium tax credits. These credits are competitively set based on a benchmark plan. Currently, eligible employees pay no more than 8.5 percent of in-

come for that benchmark plan, with lower income people paying lower percentages. These tax credits are like vouchers. With your tax credit, you can shop for any plan in the Marketplaces.

While improvements can and should be made, the Marketplaces work. Premium growth has averaged just two percent in the past five years, choices have expanded, and enrollment doubled since 2020 to 24 million people. About half of these people are self-employed, or small business workers, and many are rural residents or veterans.

Marketplace coverage is especially important for older Americans. Nearly one in four Marketplace enrollees is aged 55 to 64. Nearly one in ten older Americans relies on coverage purchased on their own, and the uninsured rate among people ages 50 to 64 has dropped by 50 percent due to Marketplace changes and the other ACA reforms.

This is about to change. The budget reconciliation law and recent rules will reduce Marketplace coverage. Moreover, the enhanced premium tax credits currently in place will end in December. As a result, the average Marketplace enrollee will pay more than twice as much out of pocket for premiums starting in January.

There's no historical precedent for such a large 1-year increase for so many Americans. The cost increase will be even higher for people with incomes above 400 percent of the federal poverty level if the cutoff of premium tax credits is reinstated. Over half of people losing tax credit eligibility will be people ages 50 to 64.

For example, a 60-year-old couple with income of \$85,000, will face an average increase of \$22,000. This represents 27 percent of their household income. The impact varies by location. The same couple will pay \$28,000 more in Savannah, Georgia, and about \$31,000 more in Caribou, Maine.

To put this into context, if this couple paid that extra amount until they become Medicare eligible, it will consume over 60 percent of the typical retirement savings. Others will simply be unable to afford these premiums. They'll become uninsured. Older people losing coverage are at greater risk of unmet needs, worse health, and premature death.

The impact will extend to other Americans as well. Medicare costs are likely to rise to pay for the unmet needs of previously uninsured enrollees. The individual market stability and affordability will be reduced according to all insurance commissioners across the country, and in the words of the American Hospital Association, there will be an impact on the entire community, even those with coverage, because of an influx of uninsured patients into emergency departments causing longer waits, stressing the whole healthcare system, and the inability to get the care that they need.

In conclusion, Americans want clear choices and affordable options for health coverage as well as healthcare. Extending tax breaks for private health insurance can help achieve that goal.

Thank you for the opportunity to present this testimony.

The CHAIRMAN. Thank you. Now, we'll go to questions. We'll start with Senator Tuberville.

Senator TUBERVILLE. Thank you, Chairman. Thanks all of you for being here today and talking about a subject that's very impor-

tant to all Americans across the country, and as Dr. Smith said, an out-of-control healthcare system, which it is.

Mr. Cuban, innovative companies like Cost Plus Drugs have already proven that bypassing traditional PBMs can deliver real savings at pharmacy counters. President Trump has announced Trump RX, a new website to connect patients directly with the best prices. How might Trump, and RX, and direct patient programs improve affordability for patients, your basic, while you're doing this?

Mr. CUBAN. Yes. I mean, we'll work with Trump RX. I mean, it's incredible. It's stupendous. It's like the most incredible program ever, and so, we're excited to offer them our API so that they'll be able to download our daily prices so when they go down, everybody benefits.

Plus, I like what they're doing with the MFNs because as I mentioned in my comments, our brand drugs are more expensive because PBMs are involved, and with Trump RX and the MFN program, that allows manufacturers to work around the PBMs and work directly to patients. I think it'll save seniors. It'll save everybody a lot of money.

Senator TUBERVILLE. You think this is the future?

Mr. CUBAN. I don't think it solves the ultimate problem of how the system is designed, but I think it's something that we obviously agree on because that's what Cost Plus Drugs is; we publish our entire price list every day.

Senator TUBERVILLE. Your company posts drug prices with full cost breakdowns. How does this transparency help save patients money?

Mr. CUBAN. I mean, you know, with costplusdrugs.com, any patient can just go look at their price for their medication, and so there's no uncertainty, but more importantly, by seeing our markup of only 15 percent and seeing our costs, that builds trust. I always tell everybody in our company that what we really sell in this industry is trust. I think that's what's really allowed us to grow so quickly.

Senator TUBERVILLE. If you sold Ozempic and somebody else went through PBMs how much cost would they save?

Mr. CUBAN. Well, if you look at what's happening now where the PBMs work with sponsors, they're typically being charged \$1,300. If you look at the direct-to-consumer programs that are being put out there by Novo and Lilly, it's \$499 or less and probably falling. There's already a significant difference, and the crazy part is that difference of \$800 typically goes right into the pocket of the PBM, who then decides how much they're going to give to the employer. It's a huge amount as of right now.

Senator TUBERVILLE. Thank you. Dr. Smith, the Surgery Center of Oklahoma has proven that real price transparency can lower cost and improve patient access, which is something we often hear discussed in the context of PBMs and prescription drugs.

What inspired you to create this transparent surgical model, and what parts of the traditional healthcare system, much like PBMs in the drug space, were you trying to get around?

Dr. SMITH. Well, we started the Surgery Center of Oklahoma because, frankly, practicing in a big hospital as an anesthesiologist, I served as an accessory to a financial crime. Surgeons were also

being denied the tools, many of them required to appropriately treat patients due to the cost-cutting measures at hospitals trying to maximize the revenue.

I didn't grow up in a home like that. I grew up—it was a golden rule; mutually beneficial exchange. As a hospital-based physician, the only way I could escape that was to own and control my own facility. Where I was responsible to the patients, not just for the medical treatment, but also the way financially we dealt with them.

If a patient asks, you know, "What can you do about this bill?" My answer was everything including not charge them. We're in a good position to be charitable on an individual basis. That's really the answer. We started it because we wanted to be in control of the medical and the financial journey the patient had in their healthcare experience.

Senator TUBERVILLE. You know, some people argue that patients won't shop for care, or that is too complicated to understand. Do you think that is true? What savings have you seen for patients when prices are available?

Dr. SMITH. Well, patients will not only shop for care, but they'll vote with their feet. Half the patients we see at Surgery Center of Oklahoma do not live in Oklahoma, and we see patients from Europe, and Africa, all over the United States.

Self-funded employers see such an insane price difference between our prices and the local hospital where they're doing business. They waive all out-of-pocket for those employees and a companion to fly to surgery at General Oklahoma and have their procedure, and not just us, but those who've copied us.

People will shop, and they'll travel, and furthermore, they'll hold our price up in front of their local hospital and tell them, match this, or I'm going to Oklahoma City. We had a patient from Georgia that was going to be charged 40,000 for a urologic procedure, and our online price was 4,000, and the hospital matched our price. Because that would've been the second patient that month that came to Oklahoma City, and they didn't want to see that. The patient reached out to me later and said, "You saved me \$36,000, and you didn't even perform the surgery."

There is a market that is developing. It's a competitive market. It's driving prices down. It's driven prices down Oklahoma City, I know, and quality goes up at the same time.

Senator TUBERVILLE. Thank you for what you're doing. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Tuberville. Ranking Member Gillibrand.

Senator GILLIBRAND. Thank you very much. Ms. Lanmbrew, why do so many adults between the ages of 50 and 64 rely on the enhanced premium tax credits, and how do you anticipate adults between the age of 50 and 64 will be impacted if these enhanced premium tax credits are not renewed? How will they be able to save for retirement? What will the impact be?

Dr. LAMBREW. Yes. Just to start with—we know that as people approach age 65, they often go to part-time work, some retire early, some are forced to retire early. Those working in a hard construction job or some other physical job just can't make it till age 65

when they can enroll in Medicare, which is why we really see 23 percent of all of our marketplace enrollees are in that age group versus 15 percent of the rest of the population, so it definitely is a more important source of coverage for that group.

It's also important for rural areas where we also know residents are older. Farmers typically don't get employer-based insurance. They have to buy coverage on their own. We just know that these demographics make it more important for them, and the numbers are pretty stark that the cost of health insurance across the board is too high.

We should look at all available options to lower employer coverage, Medicare, Medicaid, and Marketplace coverage, but for these people right now to be facing these kinds of numbers, again, an average of over \$20,000 for a couple at 60, that is impossible for a lot of these families to deal with, but your choices are, if you're chronically ill, do I pay that amount to maintain my coverage or do I become uninsured? And what does that mean?

I do wish many of these programs that we're talking about today would be a solution for those people. They will help. I have no doubt that these will help, but I think there's more that will be needed for people who are older, chronically ill, who are about to face these hard, large coverage or large out-of-pocket premium increases.

Senator GILLIBRAND. Thank you, Doctor. Mr. Cuban, can you speak to this conversation about unaffordable deductibles? Can you talk a little bit about what this will result in, whether it's increased hospital visits, emergency room visits. What does this vicious cycle of unaffordable healthcare cost lead to, and how does it stress the healthcare system?

Mr. CUBAN. Well, no matter what your premiums are and you pay them, if you can't afford your deductible, you don't really have insurance, and what ends up happening is either you go to the emergency room, you do nothing at all, or you are at the mercy of the provider hoping they can provide some sort of financing for you. Either way, it creates very difficult situations for seniors, for entrepreneurs, for anybody in that situation.

You know, as I alluded to in my comments, we don't do anything to help people who are unable to afford their deductibles, and in fact, we make it more difficult. Dr. Smith alluded to the fact that, you know, the cost of a surgery could be extremely high, and if you can't afford your deductible, you can't get it. In the case of pharmacy benefits, if you have a drug like Eliquis where the list price is \$600, and you have a \$4,500 deductible under an ACA silver plan, you're going seven months having to pay full list price, and if you can't afford to do that, you're out of luck.

Senator GILLIBRAND. Right. Dr. Smith, you mentioned how an increasing number of physicians are either opting out or severely limiting their exposure to Medicare patients. Why are physicians increasingly dropping Medicare, and how are these patients going to get the care they need?

What factors are driving up the cost of providing care, particularly for older adults, and what can be done on the federal level to provide greater stability for these practices to enable them to treat older adults?

Dr. SMITH. Yes, I think Medicare is a burdensome quagmire. It's heavily regulated. I probably get 10 emails a day asking me to pay somebody to attend a course to figure out how to navigate this new regulation that's come out. It's very burdensome.

Also, the payments to individual physicians. The independents have not really kept up, and frankly, they've been wrong. Top-down pricing seems to always be wrong. It's either too high or too low, and that's what happened when RBRVS came into place in 1992. True pricing comes from market activity, and that's absent in the Medicare program.

Senator GILLIBRAND. That's right.

Dr. SMITH. When an anesthesiologist like me is paid \$78 for the anesthesia required for a surgeon to do a knee replacement, that's a message, and message sent, message received. The last open-heart surgery for which I provided anesthetic in 1992, Medicare paid me \$285. I knew it wasn't personal. You know, prices are just signals, and that wasn't personal.

That was just an idea of what my time was worth, and I walked away, and I haven't accepted Medicare payments since I treat patients free of charge instead of file claims, but it's payments, and its regulatory burden, and frankly, risk.

Senator GILLIBRAND. Yes. Thank you.

The CHAIRMAN. Thank you. Senator Johnson.

Senator JOHNSON. Mr. Chairman, again, excellent hearing. I think it's kind of notable when you have a hearing on how to improve outcomes and lower costs. Most Republicans show up, we have the ranking member here on the Democrat side. It's pretty interesting. We're looking ahead on how to do that, but I think in order to fix a problem, you have to really define what the problem is. You have to look at the past, and I don't want to dwell too much on the past, but right now there's been a lot of talk about extending the enhanced temporary subsidies that were put in place to help people through the pandemic.

I have talked a little bit about Obamacare, and Ms. Lambrew, you were part of the Obama administration during the—after the passage, but leading up to the implementation of it.

Dr. LAMBREW. Correct.

Senator JOHNSON. You were there when President Obama was out there saying that Obamacare would lower the average premium for a family by \$2,500 a family. Correct?

Dr. LAMBREW. I was there when we talked about slowing the growth of healthcare. Yes.

Senator JOHNSON. President Obama made that claim, right, \$2,500 lower premium per family. Correct?

Dr. LAMBREW. Over time with slower growth.

Senator JOHNSON. Okay. That hasn't panned out, has it?

Dr. LAMBREW. It has.

Senator JOHNSON. It has not.

Dr. LAMBREW. We have seen slower growth in the health insurance profit base.

Senator JOHNSON. Inflation has gone up 39 percent since 2013. I've seen, again, it's very difficult because you have a whole range of premiums, but just one benchmark premiums up to 118 percent.

That's three times the rate of inflation, so no, that was, did not occur.

Premiums have skyrocketed because of the faulty design of Obamacare. President Obama said, you can keep your doctor, you can keep your healthcare plan. That was PolitiFact 2013 "Lie of the year." Correct?

Dr. LAMBREW. Today, there is no lower percentage of people with employer-based covers than there was.

Senator JOHNSON. People lost their doctors. For example, Obamacare, outlawed high risk pools, which worked beautifully in states. They worked beautifully in Wisconsin. As an employer, we used them all the time. It worked great. You outlawed those. You outlawed short-term plans. Again, that was PolitiFact 2013 "Lie of the year."

Let's just look at enrollment history. Obamacare impacted Medicaid expansion, and then, there's problems with that, but let's focus just on the individual market. That was the other thing that Obamacare, again, fix all these, you know, this marketplace for individuals.

There were about 12 million people prior to Obamacare taking advantage of the individual markets. You completely disrupted that, got rid of high-risk pools, got rid of short-term policies. Before the pandemic, there were 14 million people on the Obamacare exchanges, so two million more people on these individual policies. Then all of a sudden with the enhanced premiums, all of a sudden, we're up to 24 million people.

Now, are you aware of the problem we're having with the no premium policies and phantom policies where you have unscrupulous agents and brokers signing people up without their knowledge? They get a commission. The premium tax credit goes directly to the insurance companies. We've seen estimates of \$20' to \$30 billion per year of premiums going to the insurance companies on phantom policies. People make no claims on them. Are you aware of that?

Dr. LAMBREW. I am aware that there are agents and brokers that have been falsely signing people up. Last year, action was taken, 500 of them were unsubscribed—

Senator JOHNSON. Again, so we've gone from—

Dr. LAMBREW [continuing]. this year, the H.R. 1 did include many policies to address that, but the reality is that those people are the victims, and we are trying to make sure that we keep these people covered.

Senator JOHNSON. My point being, we went from 12 million to 14 million, now up to 24 million. That's not 24 million real people. The uninsured in the country, there million

Dr. LAMBREW. The uninsured rate in this country has dropped, sir.

Senator JOHNSON. Again, you're saying this is going to be a huge problem. Now, isn't it true that the original design of Obamacare, there were no subsidies for people making more than 400 percent of the poverty line? Correct?

Dr. LAMBREW. Yes, there are currently three to four times more subsidies for people—

Senator JOHNSON. Just answer the question. The original design of Obamacare, nobody above—working, is making more than 400 percent above the poverty line, got a subsidy. Correct?

Dr. LAMBREW. People who have employer-based coverage get a subsidy. People with Medicaid get a subsidy. People before the Affordable Care Act buying coverage on their own, the retirees, could not get help from the Federal Government.

Senator JOHNSON. The enhanced subsidies started providing subsidies for people above 400 percent poverty. This is talking about people who have higher, higher out-of-pockets that didn't qualify for subsidies in the original Obamacare. The subsidies aren't going away when the enhanced premiums go away, they still—the original design of Obamacare stays in place. Correct?

Dr. LAMBREW. We know that people have been significantly helped by the improvements that were made in 2021, and people will be hurt if they leave, so many pandemic policies; telehealth—

Senator JOHNSON. Those were temporary enhanced tax credit. Those were temporary enhanced subsidies, and the Democrats in their law, they scheduled them to expire this year. Right? Republicans had no point in that at all.

Dr. LAMBREW. The 2017 bill—

Senator JOHNSON. That all that was designed by Democrats to expire—

Dr. LAMBREW [continuing]. also extended policies that ended, that just got extended without being paid for. Tax extensions happen all the time.

Senator JOHNSON. You are claiming harm to people that never qualified for the subsidy under the original Obamacare. Now, you're also saying, because you're quoting people at the hospitals, if these enhanced subsidies expire as they were meant to do by Democrats, it's going to be a calamity for the hospital industry. How all's happening is we're going back to the original Obamacare, so what you're saying is going back to the original design of Obamacare is going to be a calamity for hospitals.

Dr. LAMBREW. Going back to 1965 practices for medicine are also a calamity. I mean, we figured out something that worked. It should be extended. People have been helped by it. Costs have been growing slower than private employer-based coverage, choices have gone up. Could it be improved? Without a doubt.

I think it is a fact that the uninsured went down. Cost growth has not been excessive. We have more choices. Deductibles have actually gone down. We really have seen in the last few years people able to choose deductibles that are now on average \$400, not the higher amount.

Senator JOHNSON. Ms. Lambrew, my point is a number of goals. My point is, if these enhanced subsidies expire, all that happens is we go back to the original design of Obamacare, which didn't work, didn't lower premiums, people couldn't keep their doctor, couldn't keep their healthcare plan. It's been a disaster.

The reason Democrats want to extend these subsidies, the reason we have subsidies is to mask the fact that Obamacare drove premiums sky high, and what this hearing's about is how can we bring those actual premiums down, deliver better outcomes.

We've got some great examples here. Doctors from Oklahoma is doing some marvelous things called bringing consumerism the free market principles back into healthcare. Republicans are interested in that. Democrats aren't. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Johnson. Senator Husted.

Senator HUSTED. Thank you, Mr. Chairman. I appreciate you hosting this hearing today, and I know that—I want to start out by healthcare inflation is a problem for everybody in the American economy. It's the number one driver of inflation in the 21st century. What we have now doesn't work, and so, hopefully, we can constructively have conversations about how we make it work.

One of the ways that we have driven down some costs are over-the-counter drugs, moving prescription drugs to over-the-counter drugs. It saves American consumers \$170 billion annually. Working with Senator Hassan we have a streamlining marketplace, access, and reform for therapeutics called Smart OTC Act, which will help the FDA identify drugs that could be candidates for over-the-counter and help companies move those to over-the-counter more quickly through the FDA. I would encourage us all to look at that as we move forward.

Now, Mr. Cuban, thank you for the example that you used with the monopoly and Amazon that's in consumer products, which we know is troublesome. You know, monopolies create higher prices, lower quality in general, but that's in a consumer marketplace. Healthcare, oh my gosh, people don't have choices at all. They have no choice, for most people, about where they go to consume that healthcare.

I think that you make a great point, but the healthcare system seems to be conspiring to create a monopoly, marketplace monopolies, across all aspects of what it does for a service that everybody must have, which makes the pressure of cost and quality even more stark.

I do have—Mr. Moulds, I want to ask you a question about anti-competitive contracting for healthcare. Because we know it creates a monopoly environment. It increases costs. I'm going to give you four examples, and I want you to react to these all or nothing clauses, anti-steering, most-favored nation clauses, gag clauses, which create anti-transparency. All of those carve up marketplaces and don't allow for competition. I want your thoughts on what eliminated them, and we might do to improve patient benefits, quality, and lower costs.

Dr. MOULDS. We've actually been involved in litigation on some of these at CalPERS in California. The all-or-nothing clauses in particular were the subject of a lawsuit there, and in general, you know, they are some of the challenges, but by no means the only challenges we are seeing in California, increasing consolidation, not just in the north. I mentioned that our costs are about 35 percent higher in the north, but in the south where we've historically seen pretty good, comparatively good—

Senator HUSTED. If consolidation, though, in contracts that restrict, isn't that—

Dr. MOULDS. Some of the contracts—

Senator HUSTED. The combination, isn't that lethal?

Dr. MOULDS. Potentially. Absolutely, yes, but some of these provisions we don't see as commonly in contracts in California anymore, but we still have consolidation.

Senator HUSTED. Mr. Cuban, you understand markets pretty well. You have a reaction to those?

Mr. CUBAN. Yes, I think it's awful. As an example, we wanted to build on CalPERS, and it was fair, they told us that we didn't carry certain brands, but we just asked, why not add Cost Plus Drugs to your network? Because if we're cheaper, buy from us, and if we're not, don't buy from us.

Cost Plus Drugs doesn't have exclusives with anybody. We just stand by the fact that we think we'll be better for patients because we're less expensive, and so, we were told, and this isn't just CalPERS, any of the big PBMs, when I go and speak to a CEO, I give them the test, and the test is just ask your PBM if you can add Cost Plus Drugs to your network and only use us if we're less expensive. 100 percent of the time, they've been told no.

Senator HUSTED. Mr. Moulds, do you have something you want to add to that?

Dr. MOULDS. Well, I want to just start by saying that Mr. Cuban's work in this space has actually been enormously helpful to us. Having his prices out there has helped us negotiate prices in our contract, so we are grateful for that. We did negotiate in our most recent contract that starts in January, provision that allows us to carve out so we continue to look at where we can—

Senator HUSTED. Is that a yes?

Dr. MOULDS. That is a always open to the conversation not a yes.

Senator HUSTED. Well, I'll just close with this, is that you talked about consolidation. You have these tools that are used inside the marketplaces where people want to consolidate. They want to limit others competing in their space, which allows them to basically command whatever price they want.

No market would work well like that, but in a healthcare marketplace where people don't have choices, I can decide if I'm buying water, I may not, I may decide to buy something else, but in healthcare, I don't have a choice, and I know that that's what Mr. Smith's trying to create; choices, but I'm hopeful that we can eliminate some of these tools that are being used to carve up markets and drive up prices. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Warnock.

Senator WARNOCK. Thank you, Chair Scott, and Ranking Member Gillibrand for organizing this meeting or this hearing, I should say.

Nine months ago in this committee, I warned that seniors in Georgia could see a \$20,000 annual increase in healthcare premiums should congressional Republicans let enhanced affordable care tax credits expire, and here we are just over a week before the start of open enrollment and we're in an even worse place than we were nine months ago.

Mr. Cuban, most Americans probably know you as an investor in startups and innovative small businesses. I'm a fan of Shark Tank.

Mr. CUBAN. Thanks.

Senator WARNOCK. In that role and as an entrepreneur yourself, is it fair to say that you know a little bit about how small business

owners and entrepreneurs think about their money and startup expenses?

Mr. CUBAN. I would say so, yes.

Senator WARNOCK. Would you say that among those considerations and expenses, that includes their healthcare expenses—

Mr. CUBAN. Yes.

Senator WARNOCK [continuing]. and how their healthcare costs factor into their plans for growth and sustainability?

Mr. CUBAN. Yes, sir.

Senator WARNOCK. Let me show you something. These are the—this is the cost of the premium for a senior in 2025. This person is 62 years old. Small business owner in Georgia, taking home just \$65,000 in 2025. The other side show the cheapest option for that same Georgian, so \$228.17 a month. Now, with the expiration of these tax premiums, \$1,142.71 cents. That's quite a jump.

How would this monthly jump affect that Georgian's ability to grow her small business or even just make ends meet?

Mr. CUBAN. It makes her make a lot of hard choices, either to try to find the money to pay for the premiums or to go without insurance, and I think the greatest challenge has been in all of this is that small business owners, Americans that are on the ACA, haven't had enough time to plan for it.

It's one thing to know that your premiums are going up, it's another thing not to know how much and how soon, right? Now we're just—you know, in Texas, people are just now starting to see open enrollment and more we'll see in a couple weeks, and as a small business looking to the ACA for their employees, it's going to be terrifying for them.

Senator WARNOCK. If they forego insurance, is it fair to say that, well, that would drive up premiums for everybody?

Mr. CUBAN. Yes, of course. You know, because healthy people are going to be most likely not to take insurance, right?

Senator WARNOCK. This gut punch for small businesses impacts the overall economy because small businesses are such a big part of our economy.

Mr. CUBAN. Well, of course, if you take—you know, there are 33 million companies in this country. 30 million of them are solopreneurs, one-person entrepreneurs' companies, and if you are taking \$800, give or take, a month out of their pocketbooks, they can't invest it in inventory, et cetera, et cetera. It makes it much more difficult to run your company.

Senator WARNOCK. Yes, I would imagine that come November 1st, more of my colleagues on the other side of the aisle will start hearing from folks in their own states who won't be able to afford their healthcare next year.

In fact, millions of people across the country are starting to log on today to see their plan premiums for next year double, and that's not the exception. Like, that's quite prevalent. People are seeing their premiums double, as you see here, triple, quadruple, all because my friends on the other side of the aisle refuse to fund the government and fund healthcare.

Dr. Lambrew, why are older Americans especially harmed, older Americans especially harmed, by the expiring premium tax credits?

Dr. LAMBREW. Well, in addition to there being more of them in the marketplace than would be in the general population, we also know that older people have greater healthcare needs, so we look at the average healthcare costs for a 55-to 64-year-old. It is three times the average healthcare costs of an 18-to 24-year-old, so their needs are greater.

That also means that if, when, these price increases hit them, it will probably force those harder choices. Again, "Do I follow the advice of my doctor? Do I take a medication as needed, or skip pills, or forgo them? Do I choose between my retirement savings, my groceries?"

There was a story of a woman from Georgia who's 57-year-old who said, "This amount may not seem much to the government or to the insurance companies, but for me, it would most likely mean sacrificing essentials, groceries, gas, basic necessities that I rely on."

Senator WARNOCK. Given that reality, do you think it's a good idea for Congress to wait until December 31st to address this crisis?

Dr. LAMBREW. I do not. People are shopping in Idaho already. They're looking in 12 or 13 states at the actual prices they're going to pay. A week from Saturday, they're going to go in, and we know from last years' experience three million people came in the first two weeks, and if they come in and their prices are going to be much higher than they expect, they may never come back.

Senator WARNOCK. Thank you so much. This is a crisis. It needs to be addressed right now, and I would urge my colleagues to join us in funding the government and extending these healthcare premiums for the healthcare of millions of Americans. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Moody.

Senator MOODY. Thank you, Senator Scott. I appreciate you calling this hearing. I'm one of the newest U.S. Senators, and it pains me to say about every hearing I'm in, we hear more and more ways government can throw money at a problem to fix it, and it's so great that we're having a hearing on outside of government, throwing more money at a problem, ways that we might actually bring down prices.

I appreciate all of you being here today, taking time to be here. Many of you have experience in this area and have great suggestions on this and experience on this topic. I think the next step is our chairman might hold a Shark Tank for healthcare ideas on how to bring—just be ready, that's the next invitation, I'm sure.

You know, in most every other industry, we expect a fair and free market, and it's always expected that you would know the prices as consumers when you're shopping. It seems to be the only area where we don't have transparent pricing, especially, and we especially need to focus on it, when shoppable services represent 35 to 40 percent of U.S. healthcare spending.

If the data's right and we spend \$14,570 per person per year on healthcare, that is more than per capita than any other country on Earth, and that just is insane to me. Thankfully, we have leadership that's digging in and trying to figure out how we can come up with new ideas to tackle prices.

What was shocking to me is that, and when I look back over the course of my own medical history, it's so clear and it's been there all along; you never find out how much things cost until months later when bills start showing up. In fact, only 17 percent of Americans know how much their healthcare products or services cost before they receive them. That is insane, and no wonder no one is shopping. It's a captive market of consumers.

I appreciated hearing your testimony, Mr. Smith, about the Surgery Center of Oklahoma and how you challenged other facilities to offer competitive pricing. The one example you gave was, one family was quoted \$72,000 for a procedure at a major hospital, and then when they found their way to you, they only paid \$3,875. Since you opened your facility, how many other facilities started like yours, either in your state or nationally, that you know of

Dr. SMITH. If you include all of those on the continuum who are either posting prices or agreeing to enter into single-case agreements for a single case, for a price, to those who will quote a price over the phone but won't write it down, it's in the hundreds. It's not in the thousands, but it's such a dynamic situation because every time a big hospital or a surgery center that's not inclined to reveal prices is faced with losing a patient.

To me, well, Bridge Surgery Center in Indianapolis, to Texas Free Market in Austin, and anyone that's a member of the Free Market Medical Association, they have to step up now and match those prices or they lose those patients, and it's about half the people in the country that have sticker shock, either directly or indirectly, through their proxy buyer, their self-funded employer.

Senator MOODY. When you started, were there any federal regulatory or statutory hurdles to you starting this clinic up, or have you been faced with those since you started? Is there anything that we can do to make it easier for places like yours to start?

Dr. SMITH. The two hurdles that I think this movement faces are; one, is the overpayment that is sent to hospital-owned doctors and facilities by Medicare. Because they use that extra money to consolidate the industry and to run independent physicians and facilities out of business. That site neutrality is what I think people are talking, and I don't advocate paying the independents more. I advocate paying the hospitals less.

Senator MOODY. How quickly, after you started, did you start seeing the market adjust around you?

Dr. SMITH. I'm sorry?

Senator MOODY. After you started your first surgery center, how quickly did you see the market adjust to start trying to be competitive with you, or did you not see that?

Dr. SMITH. We did not see that really until I posted the prices online in 2009. When we opened in 1997, the response of the industry was to try to crush us through the state legislature. In 2009, when we posted the prices, that's when we began to see price matching, not just in Oklahoma, but all over the country because patients will travel to have surgery performed.

Senator MOODY. Thank you, Chairman.

The CHAIRMAN. Thank you, Senator Moody. Senator Warren.

Senator WARREN. Thank you, Mr. Chairman. Thank you for holding this hearing, and thank you, Ranking Member. Military fami-

lies keep us safe, and DODs TRICARE program, it's supposed to keep those military families healthy. Since 2009, the TRICARE pharmacy benefit has been administered by Express Scripts, the Nation's largest pharmacy benefit manager, or PBM. Express Scripts decides which pharmacies are in-network or out. When one of those nine million military families' needs to pick up a prescription, Express Scripts decides where they can go to have it filled, and then they pay the pharmacy.

Now, Express Scripts is owned by the multi-billion dollar health insurance company, Cigna, and Cigna also owns a mail order pharmacy called Accredo that participates in TRICARE. In other words, Cigna owns the company that pays the pharmacies and it also owns the pharmacy chain that is getting paid the result.

Well, Express Scripts can reimburse the other pharmacies and give inflated payments to its corporate cousin, Accredo. Express Scripts has been caught doing exactly that kind of self-dealing in other government programs, but right now, the Department of Defense refuses to check how much it is costing taxpayers and TRICARE.

Mr. Cuban, you understand this business. Let me ask you, would requiring Express Scripts to disclose the difference between what it pays its affiliated pharmacies and the unaffiliated pharmacies help save taxpayers money or cost taxpayers money?

Mr. CUBAN. It would save a lot of money, and it would keep smaller independent pharmacies in business.

Senator WARREN. Okay. You know, that makes sense to me. It seems pretty common sense here. More transparency would save taxpayer money, but the Congressional Budget Office disagrees with you and me on this. According to the CBO, price transparency would cost taxpayers money because other pharmacies would allegedly join together to demand higher reimbursements. That's their argument here.

Mr. Cuban, you talk with pharmacists a lot. Do you think that independent pharmacists don't know that Accredo right now is getting a sweetheart deal, and that the independents are just waiting for information to be told so that they could demand more money?

Mr. CUBAN. I can't speak for all the independent, but I can speak for costplusdrugs.com, and so, I went to TRICARE, and I have done this in the past many times and looked up the price of some common low-cost drugs, so you know, just recently, I looked up and our price is lower, whether it's 30 or 90 pills than the TRICARE price, is for anybody who is in-network, but off base.

If they're out-of-network, we're dramatically lower, so we don't need to band together to know that we can be cheaper. All we have to do is look at some of their prices, and it's obvious that we're cheaper.

Senator WARREN. Okay. This information is actually already out there?

Mr. CUBAN. Yes. I mean, it's just by looking at—and I'm just talking about the copays. We're not even talking about what Express Scripts, what the taxpayers still have to pay to Express Scripts, Accredo. Which is more, they're not doing this for nothing, and so, I mean, taxpayers are getting ripped off. Period. End of story.

Senator WARREN. Okay. This is where I want to see more transparency.

Mr. CUBAN. Correct.

Senator WARREN. You think that's a good thing?

Mr. CUBAN. That's a great thing.

Senator WARREN. Oh, okay. That's a great thing. Good. I'll settle for that answer. All right, so DOD claims that this hasn't affected military families, but that is based on data from—they said this has not affected military families based on data from, you guessed it, Express Scripts.

When the Government Accountability Office reviewed just a little slice of this data, they discovered, "persistent inaccuracies," including misreporting the number of people who lost access to their local pharmacies because the pharmacies were pushed out of the TRICARE network. They left for the very reasons you described, but that was just a one-time review. I'm pushing DOD to audit this information every single year.

Dr. Lambrew, you served as commissioner of the Maine Department of Health and Human Services, so you understand the importance of program integrity. Do you think that auditing this program would help save taxpayers money, or cost taxpayers money?

Dr. LAMBREW. Senator, it would save money.

Senator WARREN. It would save money. You know, I just want to point out here, Mr. Chairman, self-dealing by the pharmacy benefit managers keeps the cost of prescription drugs high, both for the taxpayers and for consumers.

I'm going to keep pressing CBO to update their analysis of the PBMs. I hope to work with all of my colleagues to pass proposals to reign in self-dealing by the PBMs in TRICARE and beyond, including my bill with Senator Hawley that would make the same company cannot own a PBM, and an insurance company, and pharmacy at the same time. Look, we need to stop these giant corporations from ripping off American taxpayers and get a little more competition in the drug market. Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Warren. Senator Justice.

Senator JUSTICE. Mr. Chairman, thank you. Thank you to all the witnesses. Better turn the thing on. First and foremost, I mean this from the bottom of my heart, this discussion needs to happen on, and on, and on. We know we're dealing with a train wreck here, a runaway train wreck, and absolutely something's got to be done. Now, I don't have a clue in the world why on Earth transparency is bad.

Let me just say this before I go any further. I've got to just tell you this story real quick. We're in a government shutdown right now, and really included from my standpoint, I'm not very happy with the Democrats, but at the same time, I was just going down the hall just a little while ago, and there was a lady standing there that's a custodian, and she was talking to a friend of hers, and the friend doesn't know what to do, and because the friend is so upset, the friend's crying and she's crying.

I would tell us all just one simple thing, because I'm not here for anything really, and truly when it really boils down to it, at the end of everything we do, there's a name and there's a family, and we should all take that to heart.

Now, with all that being said, on top of all that, I would say to you just this, I'd go back to when I was a Governor, and I've got to read to you one thing. I'd even halfway forgotten about this, but I signed a bill when I was a Governor not long ago, House Bill 2263, into law. The first of its kind is legislation that crack down on the PBMs. It requires insurers and PBMs to pass along negotiated drug savings directly to the patients, helping lower cost, helping lower cost of West Virginia with commercial insurance.

Let me tell you, I speak in really common terms. I've just got a very quick couple of questions, but in a state like ours, Mr. Cuban, you know, many people rely on independent pharmacies. What kind of pressures are the PBMs putting on these pharmacies?

Mr. CUBAN. It's horrific. I mentioned in my testimony that, first of all, the wholesalers buy drugs at the list price, and then they sell to the pharmacies at just under the list price, which means those independent pharmacies, small businesses, are out a lot of money. For instance, on an Eliquis \$600 point price, they're out \$570 and they need to collect that money back as soon as possible. What PBMs do is not only wait to get the value of the float, but they also under reimburse them.

Instead of paying them at least the \$570 so they can break even, they pay them less knowing that there's only so much they can take where they'll either, A, go out of business, or, B, send the prescription to one of their captive pharmacies, and that in turn means they're not supporting their patients.

Let me tell you something that a lot of people don't appreciate; that last five feet between the patient and the pharmacist is some of the most important, important time any patient will ever spend. Because if they're getting medications that conflict with each other, then some really bad things can happen. We underappreciate pharmacies, and the big PBMs are literally, purposely, as far as I can tell, putting them out of business.

Senator JUSTICE. Well, I couldn't agree more. Let me just end by saying just simply just this; all of us, all of us realize the problem. All of us have got to have enough guts to do something about the problem, don't we? I mean, that's what it really boils down to.

You know, like I said, I didn't come here for anything. I've got white hair, and ride around on a scooter and I've got Baby Dog. I mean, for crying out loud, when it really boils right down to it, I speak the truth, and I ask people to help. With all that being said, the last thing I'd say is just this on a lighter note mark, when is Kyrie going to be able to play?

Mr. CUBAN. Hopefully, November.

Senator JUSTICE. It's going to match. I would absolutely love it. The last of my last I would say is just simply this; this is my prediction from a basketball coach that's coached 1,350 games, a semi-pro team, Mavericks will win it all this year.

Mr. CUBAN. Out of your mouth to God's ears.

Senator JUSTICE. Thank you so much.

The CHAIRMAN. Thanks, Senator Justice. Senator Kelly.

Senator KELLY. Thank you, Mr. Chairman, and thank you to all of our witnesses for being here today.

I'm going to start with Dr. Lambrew. Thank you for your work on implementing the Affordable Care Act, which made coverage

more affordable for millions of folks across the country, including in Arizona State that I represent. Now, with the expiration of the enhanced ACA premium tax credits and some new federal enrollment restrictions taking effect, I think it's fair to say that the progress we've made is at risk.

In Arizona, many older adults and working families rely on Marketplace coverage for insurance before they are eligible for Medicare. I've spoken to many of them, and when Senator Justice talks about names and families, these are real people. I've talked to many of them over the last couple weeks, but looking beyond next year's enrollment, the combination of the tax credit expirations and the administration's new rules and Medicaid funding cuts that are coming, this could leave Americans with higher premiums without a lot of options.

In Arizona, these aren't abstract numbers. They are real families, real people. A guy I spoke to just a couple days ago named Dennis is 66 years old. He's on Medicare, his wife is not. Lives in Lake Havasu City. He worked in ship repair for over 33 years, never went to college, just went to high school, but became a project manager. His wife is 62, she depends on ACA coverage until she's 65.

They've got three years of trying to deal with this. They pay \$440 a month for her insurance through the ACA, but they get a \$720 tax credit. When these tax credit lapse, her premium will go from \$440 to \$1,100 a month, and this threatens their retirement plans.

This guy worked really hard. They've got six kids that are nieces and nephews that they raised. They're not going to be able to live out their retirement dreams now because their excess income that they had is going to go for insurance. That's it.

It gets worse for other people. Robin, 60-year-old woman from Sedona. She says the expiration of ACA subsidies could lead to significant increases in her healthcare costs because she also gets a premium tax credit? She said it's going to make her have to decide between rent and healthcare. It's that simple for millions of people across the country; having a place to live or having healthcare insurance, and she told me that she is not looking for a handout, she's looking for a hand up.

Can you speak to the broader economic and health system effects that we could see if these policies lead to large coverage losses. How is it going to affect states like Arizona, and West Virginia, and Florida, and New York, and Kansas, you know, places that have rural areas? What should we expect to see?

Dr. LAMBREW. Thank you for that question. To talk first about the uninsured and then about reduced enrollment. We had hit a record low percentage of Americans who are uninsured in 2022, and 2023, and 2024. We actually have never done better.

The Congressional Budget Office projects that a few years out, the number of uninsured in this country will increase by 50 percent as a result of these changes, plus the Medicaid changes that are on the horizon. We know from our hospitals and health systems and other providers who try to provide care to people who may not be able to pay, may not be able to afford it.

It will strain the healthcare system, which could mean more rural hospitals close, mean more clinics really struggle to keep their hours, to keep their nurses to really survive in a climate with

less reimbursement. There will be health system effects, not just for those directly affected, but anybody in that rural community who may not be able to get the services that can no longer be sustained.

There's also a broader economic effect. Mr. Cuban talked about small businesses needing this kind of support for their workers to stay healthy. We have an estimate that 339,000 jobs could be lost just because of the expiration of these premium tax credits. Because it affects hospitals, it affects communities that are around those hospitals, and that translates into \$2.5 billion loss revenue every year for certain local governments.

Those are just two examples of the health system and the economic effects of not continuing these tax credits.

Senator KELLY. I've got some other questions. I know I'm out of time. This is obviously a complicated issue. You know, healthcare in the United States is incredibly complicated. I've got some questions I want to submit for the record to Mr. Cuban and to Mr. Smith, but thank you again to all of you for being here.

The CHAIRMAN. Thank you, Senator Kelly. Senator Marshall, thank you. Welcome to our committee hearing. You're up.

Senator MARSHALL. Thank you so much, Chairman. I appreciate the invite to come. Welcome to our guest as well. Could you imagine going into a restaurant and you look at the menu, you have your choice between a good Kansas City strip, or some day-old chicken with gravy and cream on it to make it taste good and not knowing what the price tags are?

Could you imagine you need a new pickup truck to pull the fishing boat with? And you go online, you look at a Ford, and a Chevy, and a Dodge. Of course, the Dodge is the best, but you want to look at the price to help figure out which is the best deal, but for some reason, in healthcare, it's the only industry in the world, in America, that doesn't have a price tag with it, so consumers have no idea.

When a patient would come to me and I would say, "Look, you need an infertility surgery." They would say, not, "What does it cost?" They would ask, "Does my insurance cover it?" For seven, eight years, we've been working on legislation, a price tags bill. I want to just briefly describe it to you all, if you don't mind what it does. I want to make sure I get this right.

It requires public reporting of negotiated rates, cost, and cash prices for services at hospitals, surgery centers, imaging centers, and clinical labs, so price tags for the hospital, much like Surgery Center of Oklahoma is doing.

Number two, it ensures group of health plans have access to claims data and prevents third-party administrators from restricting data access. Anyone who's ran a business, isn't it frustrating? We're trying to convert from a traditional insurance to a self-funded model, and the insurance companies won't give us our own data, whose data is that? We fix that. Number three, it requires patients to be provided an itemized bill for each succinct service as well.

I'll start with Dr. Smith. What impact would that have on healthcare costs, specifically across the country, in your guesstimation?

Dr. SMITH. I think it would have a real positive effect on costs because more companies would self-fund, and self-funded companies are essentially our proxy buyers for individuals. They have the same sticker shock that an individual does, and if a company has their own data and they can actually look at claims, they can compare what they paid.

Senator MARSHALL. I think you got a great point. The only one whose health insurance costs are not going up are self-funded plans that have a direct primary care doctor running that, the folks in there as well. Do you think it would bring down the prices of the hospitals you're competing with? Would they bring their prices down?

Dr. SMITH. Oh, absolutely, and because the self-funded companies with sticker shock would patronize price-transparent facilities like mine, and the hospitals would have to match that or they'd lose all that business.

Senator MARSHALL. Mr. Cuban, you could talk about the pharmacy industry, how PBMs hide it, or you could just talk generally about healthcare, what the impact of a price care, price tax bill would do. What do you think?

Mr. CUBAN. It would be great. I mean, like for my companies, we're already starting the process of direct contracting, and the only way you can direct contract is if you know the prices, and by knowing the prices, we can make our own determinations about what our cost of care would be. Because once we have our claims, we can look at our historical claims and kind of extrapolate to see where they're going.

Point number two to that, is it would crush the big insurance companies because it allows us, and this is what we're doing, to direct contract with providers and b, just work with a third-party administrator to handle all the services and just figure out the care navigation with a third-party as well. You know, it's rare that insurance companies take all the insurance risks these days, and so, this is just one more way to accelerate the move from them toward people, companies, in particular, taking responsibility for all of their own care.

Senator MARSHALL. Dr. Moulds, do you have anything to add to what the impact of the price tags bill?

Dr. MOULDS. No. Anything that can be done to increase price transparency from our perspective is going to be a good thing. You know, we have a much better sight line into prices because of our size. We require a lot of information through our contracts. There's still opacity out there, but for folks who are smaller employers, for example, they often don't, and they don't have the same kind of sight line, and it's incredibly important for them as well.

Senator MARSHALL. My belief is whatever we can do to turn patients into consumers, again, is going to help bring the cost of healthcare down, and if you want to be a consumer, you have to know the prices as well.

Mr. Cuban, you want to talk a little bit just about the opaqueness of PBMs, the traditional PBMs, and how they truly are hiding the cost from my mom and dad when they go to their local pharmacist.

Mr. CUBAN. You know, Cost Plus has been in business for three and a half years, and we're still the only pharmacy that publishes their entire price list. As Mr. Moulds mentioned, he used us as a reference price when the FTC investigated the PBMs. They use Cost Plus Drugs as a reference price, and so, they're doing all they can to prevent transparency.

They also do the same thing with contracts. Anytime you have a contract with an employer in particular, or State, or Federal Government, they always put in there maybe other fees that we charge you. Right? Then, they'll play games like with rebate GPOs. What a Rebate GPO is, you would think a PBM is big enough to just negotiate with the brand manufacturers and get the best rebates they can, but that's not what they do. They create these intermediary subsidiaries called Rebate GPOs that in turn go and negotiate with the brand manufacturers.

Take let's, in any given example, 60 percent in rebates given back 40 percent to the actual PBM, who in turn goes to the plan sponsor and says here's the whole 40 percent, not disclosing that they kept 20 percent through their Rebate GPO.

Those are the types of things, and there's a long list more, but I will say the one thing for every employer or anybody listening is if you're paying any fees as a percentage of a price of a drug, you're getting ripped off.

Senator MARSHALL. That's why we call it DE or Delinking. The bill takes care of that as well, and the bad news is they're moving these GPOs offshore so they don't have to obey any of our laws. Thank you so much, chairman. Thank you for holding this hearing.

The CHAIRMAN. Thank you, Senator Marshall. Senator Gillibrand.

Senator GILLIBRAND. For Dr. Moulds, CalPERS has implemented reference-based pricing for certain procedures like knee and hip replacement surgery or colonoscopies. CalPERS has also incentivized its members to use independent laboratories for shoppable lab services. You emphasize in your testimony that there is no one-size-fits-all solution for rising healthcare cost.

What factors does CalPERS consider when deciding to adopt reference-based pricing for certain procedures or services? What are the limitations in using reference-based pricing, more broadly? Are there certain procedures or services for which this doesn't work or creates a problem?

Dr. MOULDS. Thank you for the question. Yes, there are some things that are better fitted for shoppable responses. For example, the most recent reference pricing program we have is with labs. We are essentially eliminating cost sharing for our members who forego the hospital owned lab and instead go to independent labs where we've pre-negotiated a much lower price.

You know, the reason that we're structuring it that way is so that it's entirely a carrot-based intervention rather than a stick, and with a stick-and-carrot intervention, like some of our other programs, the one thing that we don't want to happen is for our members to go down to get their lab work, only to find out what their cholesterol numbers look like, et cetera, that it's prohibitively expensive, and then never seek the care they need.

We have to be thoughtful about when we do it, about the implications of foregone care. You know, CalPERS members either work for the State of California or a public sector entity like a city, county, school district, or a fire district. They stay with their employers for a very long time. Their long-term health is incredibly important to us.

It's what we're in the business of doing, make sure that they stay as healthy as possible, but also if they are foregoing care, particularly preventative services, we're going to see those costs later on down the line in the form of worse conditions that are far more expensive to treat.

Senator GILLIBRAND. Dr. Smith, can you talk a little bit about improving Medicare physician fee schedule? Because we talked a lot about the problems. Can you talk about how to fix those problems, and what your best recommendations would be for this committee?

Dr. SMITH. Yes, I'm no good at policy. I'll take a swipe at it. I think one of the first things that maybe should be considered is eliminating provisions on balance billing. If a physician thinks their service is worth \$500 and Medicare beneficiary agrees, but the fee schedule only pay them \$100. There should be no prohibition on an arrangement between that physician and that Medicare beneficiary for what they consider without any interference. A mutually beneficial exchange.

Right now, there is a hard limit on the fee schedule and no one can charge beyond that. I would probably start there, and that will make the Medicare beneficiary a pretty intense shopper, and that tends to drive prices down as well.

Senator GILLIBRAND. I feel like this hearing has been very useful. We've gotten a lot of good ideas about how we reduce costs from each of you. Some studies show that healthcare consolidation also leads to increased healthcare costs.

To any of you who want to talk about this, to what extent do you agree with these findings? And could you please describe your experiences with healthcare consolidation as increase in healthcare costs, starting with Mr. Cuban?

Mr. CUBAN. I mean, I don't have anything specific to add to that other than our own experiences that when a PBM owns a pharmacy. When an insurance company has an investment in 10 percent of the doctors out there, they are going to optimize for their top line.

I can tell you that when you look at the biggest insurance companies, they have 2,500-plus subsidiaries. You know, the intercompany transfers for just one of them alone is equal to 0.3 percent of the U.S. GDP, so you know that they're gaming the system in every way they can, and if you just intermediate them or disaggregate, separate them, you'll see prices fall because they won't be able to arbitrage the financial system.

Senator GILLIBRAND. Yes. I've seen it where even different funds acquire whole sets of healthcare practices, and they do it because they know they can make money. What I've noticed is a patient, and what my constituents have noticed as patients, is that the services decline, that you're not actually getting the quality of care that you had before.

Can you talk a little bit about that as well, any of you? Also, what does this do to rural areas? I think one of the biggest hard-hit areas it's going to be in rural areas. Because when you're a provider in rural areas, you don't have the economies of scale, you don't have the ability to do cost-cutting, but honestly, people need healthcare to survive.

Part of my conclusions about this is that if we look at healthcare as much more of a human right, as opposed to a business model, you have a different approach. Some of the things that you've offered are consistent with that. Like, let the customer know how much things cost, publish it in advance, let the market work better. Giving that information to consumers, to the patient, is vital to get costs down.

Also, in your last recommendation, Dr. Smith, you were just saying give patients more control. Because they may be willing to pay a little more than Medicare will cover to get the benefit of that doctor, and that's also interesting, so anyone can answer the question. Go ahead.

Dr. MOULDS. I mean, you know, just elaborating on some of the earlier figures that I was citing about the differences between the North and the South and California. We see a more than two to one difference in prices. When we compare our least competitive counties to our most competitive counties on hospital prices, the most efficient 10 percent are at about 62 percent of Medicare. The least efficient 10 percent are above 350 percent of Medicare, so tremendous price variation.

Mostly, you can tie it back to a lack of competition. Just generally speaking, anything that can be done to oversee consolidation is going to be of critical importance. For us, absent that, having other tools to get at those kinds of differences in areas that really, you know, when we talk about shoppable services, we provide a travel benefit for our members who are getting hips and knees if they need to go out of county.

Without that, we wouldn't be able to do reference pricing in counties that uniformly are above 300 percent of poverty—I mean, sorry, above 350 percent of Medicare. It's a tremendous problem in California.

Senator GILLIBRAND. Dr. Lambrew?

Dr. LAMBREW. I will just quickly add that I think this issue of consolidation within states, especially areas that are rural, is a great concern to state policymakers as well as federal policymakers because they're on the front line right now of some of these negotiations between large health systems and insurance companies. How do they manage kind of this cost growth that they can't actually totally control? Because self-funded plans are outside of states purview.

I think we'll see a lot of bills next year, I think, at the state level, on this topic. I will just go back to rural because I think many states are thinking hard about whether some of the funds from the Rural Health Transformation Program that's rolling out this fall can be used for different types of payment models for those rural hospitals that may be critical access hospitals.

Some of these hospitals just don't have enough volume to—even if you paid them 300 percent of Medicare to support the day in and

day out services, so thinking creatively and differently about how we support access to rural services, not just hospitals, I think, will be on the horizon as well.

Dr. MOULDS. If I could add just one point on the rural issue. Rural areas are not driving healthcare costs in California. We understand that in some rural areas it is more challenging to provide healthcare services. Some of them are still more expensive than they should be, but that's not what's going on. It is the populated areas where you still have very high prices that are driving healthcare costs in California.

Senator GILLIBRAND. Got it. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Cuban, how does the level of transparency that—your Cost Plus, right, you know your prices and then your cost, you add 15 percent, right? You just tell everybody, so everybody knows, so how's that changed behavior? How's that changed? What have you watched?

Mr. CUBAN. I mean, I look to see who's—people start shopping more, to answer your question directly, because now they know when they go to the pharmacy counter and they're shocked by a price, and we get emails, and calls, and letters all the time; "I thought this medication was going to cost me \$900. I went to cost plus and it was \$21." Then, they tell people Cost Plus is growing and we don't spend a penny on advertising, and the reason is, when you save somebody money on their healthcare and their medications, they're going to tell everybody.

The CHAIRMAN. How many employees do you have at Cost Plus?

Mr. CUBAN. Seventy, maybe. That includes manufacturing.

The CHAIRMAN. All right. How do you structure your health plan?

Mr. CUBAN. Our own health plan?

The CHAIRMAN. Yes.

Mr. CUBAN. We created something called Cost Plus Wellness, where we're going and we're doing direct contracting with providers around Texas and where we have employees. I met with a lot of CEOs and CFOs of hospitals and found out where the insurance companies were taking advantage of them. They underpay their contracted rate with high deductibles. You turned the hospital into a subprime lender with the delays from the preauthorizations, so we said we'll do none of those things. If you give us a better reference price, we'll pay you cash up-front, no deductibles and no preauthorization. We're able to get a much better price.

What we're going to do that's different at, by the end of the year, we'll have costpluswellness.com where we're going to publish all our actual contracts. Because when we talk about transparency, it's one thing to talk about prices, but most companies don't have the sophistication to understand the contractual details. We'll publish them for anybody to copy.

Then for our employees, they have no out-of-pocket when we work within the system. For our employees, for any drugs from Cost Plus Drugs, they have no out-of-pocket as well.

The CHAIRMAN. If they go outside the system, what happens?

Mr. CUBAN. If it's for healthcare, someone's in a car accident somewhere, then we have kind of a healthcare navigator, we call our healthcare CEO, that will call the hospital and say, "Hey, we'd

like the cash price." Because the craziness, part of the craziness of this healthcare industry is the biggest insurance companies will negotiate a \$25,000 rate for a hip replacement, and any Tom, Dick, or Harry walking in off the street can probably get it for \$15,000, and so, we'll negotiate directly to get the better price.

The CHAIRMAN. Do your employees have any costs at all in healthcare?

Mr. CUBAN. Yes, in some of them. Depending on which one of the companies they're in, they do, but for the Mark Cuban companies directly, they do not.

The CHAIRMAN. Okay. When you do—why do you have them have any skin in the game?

Mr. CUBAN. Why don't we?

The CHAIRMAN. Why do you have—why do they have, you know, do they have any charge at all? Why do the employees have any charge at all? What's the rationale for that?

Mr. CUBAN. I mean, it's really just because as a startup, we're progressing through all this. The goal is to get them so they don't have any responsibility because we want to use it to retain them. Now, I get where you're going with your question. You want smart shoppers going out there to be able to make the best decisions, but we'll have a healthcare CEO, CFO who goes out there and does the negotiating for them.

The CHAIRMAN. They won't have a choice.

Mr. CUBAN. Well, they'll have a choice. I mean, they'll have the opportunity, but if it's not going to cost them anything, nobody complains. Because what we're saying is, like, if you have a favorite doctor that you've always used and we're switching for whatever reason, we'll go to that doctor and say, "Hey, we'd like to do a direct contract with you. What will you charge us?"

The CHAIRMAN. What if they say no, and I'm not going to do that?

Mr. CUBAN. Then we'll pay their going rate because we want our employees to be happy.

The CHAIRMAN. Okay. Dr. Smith, are government policies and regulations helping you or hurting you?

Dr. SMITH. Well, indirectly hurting us, I think, because we pay tax, unlike the not-for-profit hospitals. As you pointed out earlier today, we also are alarmed at how aggressively hospital systems are acquiring physician practices and hiring physicians. That has decreased the number of independently—

The CHAIRMAN. Why would they do that?

Dr. SMITH. Well, yes, it's vertical integration and it's consolidation. It's all the above. The number of independent practicing physicians is dwindling in the country, and so, this movement is curtailed to the extent that they have no sort of entrepreneurial instinct or vision at all. I operate, for the most part, out of the government regulatory sphere. We accept no government payments. We just accept payments directly from that.

The CHAIRMAN. Could you open up another surgery center right now?

Dr. SMITH. Could I?

The CHAIRMAN. Yes. Is there any government limitations?

Dr. SMITH. The only government limitations on opening up a surgery center or a hospital is if you wish to accept federal payments that's illegal for a hospital.

The CHAIRMAN. Why would that be illegal?

Dr. SMITH. That was a provision in the Affordable Care Act.

The CHAIRMAN. What's the rationale for that? I mean, what you've said is your way cheaper than Medicaid and your way cheaper than Medicare. Shouldn't they want a lot of competition like you?

Dr. SMITH. Yes, I can only speculate the prohibition on opening new physician hospitals. It's actually worse than that. The prohibition expanded to, or it included, expanding, existing physician-owned hospitals. I was told that that was part of getting the American Hospital Association to the table to endorse the bill, but I'm speculating. That's just what I was told.

The CHAIRMAN. Mr. Cuban, so who's on your health plan, right? It does take Cost Plus—you know who's on your health plan, right?

Mr. CUBAN. I have a bunch of different companies, but that's generally,

The CHAIRMAN. You, I mean, the CEO of the company would know who's on the plan, right?

Mr. CUBAN. Not necessarily, no.

The CHAIRMAN. They would know who's—

Mr. CUBAN. I mean, generally, yes, but I've got a lot of different companies, so I couldn't—

The CHAIRMAN. Okay. Would you be okay if there was just an agent that could just sign up somebody and you paid 100 percent of it?

Mr. CUBAN. No, of course not.

The CHAIRMAN. Okay. Would it surprise you that in the COVID—you know, what Senator Warnock was talking about, that the way it works is an agent can sign anybody up they want as long as they know their name, address, and birthdate, and then the money goes directly to the insurance company, so does that sort of make sense to you?

Mr. CUBAN. Of course not.

The CHAIRMAN. Okay. Do you think there might be fraud? That people would take advantage of it?

Mr. CUBAN. I mean, I think salespeople are going to find ways to make money, aren't they, no matter what.

The CHAIRMAN. Yes. Dr. Moulds, so what did you—so how many different reference things are you doing? How many different procedures?

Dr. MOULDS. Eighteen at the moment—

The CHAIRMAN. Okay. How much—sorry.

Dr. MOULDS. Eighteen different procedures and they're structured differently, but in three buckets, essentially.

The CHAIRMAN. Okay. You've said that the prices in certain places of the hospitals are higher than others. Why would that be?

Dr. MOULDS. As I've said, I think a lot of it has to do with competition. Some of it is independent of that. I mean, certainly, there are places where it is harder to run a hospital than in other places.

The CHAIRMAN. Let's say Sacramento. How many delivery system, hospital delivery systems are there?

Dr. MOULDS. There are one, two, three, four—four.

The CHAIRMAN. How many do you contract with

Dr. MOULDS. All of them

The CHAIRMAN. Is there different pricing?

Dr. MOULDS. Yes. Negotiated through, generally speaking, either through the insurance companies that we contract with or through our third-party administrator.

The CHAIRMAN. How big of a customer are you?

Dr. MOULDS. Well, we're the largest purchaser in California.

The CHAIRMAN. If somebody said they're not going to talk to you, would it impact their business much?

Dr. MOULDS. Yes.

The CHAIRMAN. Okay. You were talking about rural hospitals, and I think all of us want to make sure rural hospitals stay in business. Would you do a hip surgery at a rural hospital?

Dr. MOULDS. Any hospital—

The CHAIRMAN. They do hip surgeries, and you do it?

Dr. MOULDS. For any hospital that is of sufficiently high quality.

The CHAIRMAN. How many surgeries would you want them to have?

Dr. MOULDS. Hips, as I understand it, I'm not that kind of doctor. As I understand it, generally, there are multiple knees—as in a single knee more than once or multiple single hips, pretty rare.

The CHAIRMAN. Dr. Smith, how many, if you—before you went to do a rural hospital, how many—would you want to go to a physician that did one a year?

Dr. SMITH. Yes, I would pick the physician, and they—you know, I'd say they'd need to do 100 a year. If the surgeon had confidence in a facility and the crew there, that would be the biggest indicator that they know what they're doing.

The CHAIRMAN. In a typical rural hospital, how many, if they were going to do, they do get 100?

Dr. SMITH. They would not do 100, no.

The CHAIRMAN. You probably wouldn't want to go there for your care?

Dr. SMITH. No.

The CHAIRMAN. Right. Mr. Cuban, do you think you could apply the same principle to some or other areas of healthcare? Could we do it with MRIs and CT scans?

Mr. CUBAN. Yes, particularly with those. Because it's just equipment, and some technicians, and some qualified doctors.

The CHAIRMAN. Have you worked with the department of War? Are they contracting with you?

Mr. CUBAN. No.

The CHAIRMAN. Why not?

Mr. CUBAN. I have no idea.

The CHAIRMAN. Have you talked to them?

Mr. CUBAN. I have not talked directly. When the DOD went out for one of their bids, their requirement was that thick, you know, and it just wasn't worth the time.

The CHAIRMAN. Okay. The same for the VA and same for TRICARE?

Mr. CUBAN. Yes, same.

The CHAIRMAN. Senator Warner was saying that you were checking the price, I think you said something. How did you find that you were able to look at the TRICARE book? You could see what their price was?

Mr. CUBAN. Actually, just the copays. We were cheaper than their copays.

The CHAIRMAN. Why would you be cheaper than our copays?

Mr. CUBAN. Because they're stealing.

The CHAIRMAN. Have they—I mean, is there—

Mr. CUBAN. Makes no sense. Does it?

The CHAIRMAN. Can they—

Mr. CUBAN. There's a reason why they don't publish their price list. To Dr. Moulds' point, prices vary by customer, to customer, to customer. That's how they maximize their margins, and that's how they're able to control. You know, Dr. Moulds was smart enough to get a carve out from his PBM. Most companies are not big enough, are able to do that.

The PBMs will require that you buy from their pharmacy, that you buy from, you know, specialty. The fact that there's a specialty tier for generic drugs or any drug. Every drug is special in its own way. You know, if you are being offered a specialty tier, you're being ripped off.

The CHAIRMAN. Yes. Dr. Moulds, so do you know anybody else that's gotten a carve out, and why, you're just so big you can get whatever you want?

Dr. MOULDS. We can't get everything we want. We certainly try to get the things that we think we need. We do not get everything that we would like to have in our contracts. I am not aware of other entities offhand that have carve outs. It would not surprise me if larger purchasers sometimes.

The CHAIRMAN. Have you been able to get into any employers that way?

Mr. CUBAN. There's more and more carve outs now for GLP-1s because one PBM sold their access to the formulary and excluded another GLP-1. Some of those large customers are able to get carve outs for GLP-1, specifically, but typically, we'll push, we will get those big companies to start working with transparent PBMs that include us in their network.

The CHAIRMAN. Dr. Moulds, what will it take for Mr. Cuban to get your business? I mean, how can he get in? Because you did it because of somebody like him. Right?

Dr. MOULDS. As I said, it was very helpful to have his prices published and to be able to use them in our negotiations. We looked very expansively in our most—we just renegotiated our PBM contract for a January 1st, 2026, start.

We look comprehensively at a number of different solutions, including multifaceted ones of the kind that Mr. Cuban has mentioned. There are a lot of things that PBMs do in addition to buying drugs. They distribute drugs. They help manage formularies, et cetera. You know, breaking that up is something that we always have as a vision for our future.

It is enormously complicated thing to take on. We have taken pieces of that and incorporated it in a broader approach right now, but we're not precluding a future where we do something that

breaks apart what they provide and contracting independently for those solutions.

The CHAIRMAN. Is there something that the PBMs are doing that you can't do?

Mr. CUBAN. No—I mean, let me qualify that. We don't have access to all brand drugs. What we're told from the brand manufacturers is the reason we they don't sell to us is because it's been intimidated to them from the big PBMs that if they do work with us, they will see their portfolios diminished on their formularies.

Formularies give the big PBMs 100 percent of their power. If they didn't have control of formularies—and look, there's no specific skillset that they have that the State of California couldn't recreate for creating their own formularies, right? They just go out and negotiate that formula, and effectively, auction off access to that formula.

If you disaggregated by law formularies from PBMs companies, patients would have better experiences because they would be more dependent on their doctors, and the entire rebate system would collapse like that. When the entire rebate and fees system collapsed, the price of medications would fall depending on the medication, 30 to 80 percent.

Their control of formularies gives them every bit of leverage.

The CHAIRMAN. Why do you think PBMs are started?

Mr. CUBAN. Why were they started? Yes, back in the day, it was about negotiating pricing, and that's what they did, but they don't negotiate prices today. If they negotiated prices, they would just publish a price list. Hey, and I wouldn't be in business, right? Because they're big, they should be able to buy for a lot less than we can, but they don't negotiate prices. What they negotiate is what they auction off as access to their formulary.

You see that a big part of the problem as a result is going back to when we talked about deductibles, right? All the stuff about the ACA, well, you would think of PBM, if they truly were about negotiating prices to the benefit of patients, they wouldn't make patients pay full list price for a medication until they hit their deductible.

What happens when that insured patient has that \$2,500 deductible and it's a \$400 medication, you know, out of the \$400, let's just say \$200 of it goes right to the PBMs pocket.

The CHAIRMAN. Yes. Dr. Smith, have you calculated for just the surgeries that you do, that you have prices of how much Medicare would save or just even Medicaid in your state? Take Oklahoma. Do you have any feel for what—take Medicaid. Have you ever looked at what you could save if you—if everybody just got your prices?

Dr. SMITH. I think I could answer that in a roundabout way. Oklahoma County, it's the largest county in Oklahoma, and they have 1,100 employees. The first year we were directly contracted with them, those 1,100 employees saved \$750,000 out-of-pocket. The Oklahoma County Health Plan saved \$3.25 million. Those prices we were offering were less than what Medicaid pays the hospital, but that's 1,100 lives.

I think if you extrapolate that out to the number of Medicare, Medicaid beneficiaries, it could be tens of millions, dozens of millions of dollars, easily.

The CHAIRMAN. If Medicare, Medicaid had a complete choice that people go wherever they want, and we gave the money to the enrollee, you think they could buy better prices?

Dr. SMITH. Oh, yes. You would essentially turn Medicare into the same sort of cooperative arrangement that cost sharing ministries have embraced where the member pays and then they're reimbursed, so, that caused extreme shopping. Yes.

The CHAIRMAN. They would bring them in and make them shoppers.

Dr. SMITH. Yes.

The CHAIRMAN. Mr. Cuban, you're starting to produce sterile injectables. Was that an easy process? Was the government really a good partner in helping you do get that done?

Mr. CUBAN. No, it wasn't an easy process, and if I can add one more thing on the cost for Medicare and Medicaid. There have been multiple studies that showed if Medicare bought, I think it was oncology drugs, through Cost Plus Drugs, it would save \$6 billion a year, \$1 billion a year for urology drugs.

To go back to your question on our manufacturing facility, we had to work with the FDA and it was slow, but it was efficient and we were able to get it done. Honestly now, since the change in administration, we're extending that and they've been very good to work with and much quicker.

The CHAIRMAN. Are you like three times, four times, five times the international—same thing. Your prices, are your costs way higher than if you did this in Vietnam, or India, or China?

Mr. CUBAN. No. Because we're mostly robotic, we're all robotic. I'd say we're really close to being as cheap, if not cheaper, than overseas.

The CHAIRMAN. All right. By the way, do you tell people where drugs are made?

Mr. CUBAN. I'm sorry?

The CHAIRMAN. Do you tell—

Mr. CUBAN. Oh, where the source country is? Yes, we don't. At this point in time, it's something we're discussing. We have one drug that's made in China, that might move to two. We have a bunch that are made in India, but we check and we do batch checking and all that, and we're increasing the number that we get done here.

Part of the challenge we have is the big wholesalers have these contracts with American manufacturers, and I forget the term, but it's like either deliver or your SOL. That really makes things a lot difficult for us when it comes to when—for them to be able to compete with pricing.

The CHAIRMAN. What do you think your prices, and especially as you buildup more volume, what do you think your prices are going to be on injectables versus something?

Mr. CUBAN. Well, they're already cheaper than anywhere else, right? And in terms of competitive with international, we should be less expensive.

We're changing how we do it. We've created these mobile pods so that we'll be able to not only make sterile injectables, but we'll be able to make N-of-1 selling gene therapy so we can park one of these mobile pods outside of hospital.

When they're doing all kinds of genetic, I'm not—my partner Alex over here knows this stuff better than I do, but when they're doing N-of-1 analysis, we'll be able to convert it to a biologic that they can use with a child, and it'll cost a 10th of what it currently costs.

The CHAIRMAN. Do you think you could open up generic drug manufacturing the same price as India and China?

Mr. CUBAN. Yes. Now we might not have the scale initially—

The CHAIRMAN. Yes, but once you get to scale.

Mr. CUBAN. Yes. I mean, it's robotics. It's all robotics.

The CHAIRMAN. If you're doing one billion pills a year, you think you can get there?

Mr. CUBAN. Yes.

Senator GILLIBRAND. I have to go.

The CHAIRMAN. Okay.

Senator GILLIBRAND. Should I just go?

The CHAIRMAN. Yes.

Senator GILLIBRAND. I just want to thank you guys so much for your testimony. I have to leave, he's insatiable. He's got more questions. I want to just tell you, I appreciate your testimony, and this committee is doing some really important work on how we can help older Americans, and this affordability hearing has been magnificent. Thank you so much.

The CHAIRMAN. Dr. Smith, why do you think hospitals aren't doing this?

Dr. SMITH. Well, they are. Now, many of the hospitals in the Oklahoma City area that tried to put me out of business early on are now the recipients of referrals that I send them. We fortunately had enough national exposure that patients from all over the country now ask for pricing for procedures that can only be performed in their hospital.

When a CEO or a CFO gets a call from me, it's about a patient from Florida, or Arizona, or Nevada who needs a colon resection or a brain tumor removed. I cobble those prices together and quote them to the buyer, either the individual or the self-funded employer cost-sharing ministry. Invariably, those prices are extremely reasonable. I then pay that hospital.

These hospitals are coming into this movement. They've kind of put their toe in the water, but it is spreading because they're not afraid of the carriers. They're not afraid of the carriers with a single-case agreement.

The CHAIRMAN. Yes, but if the Affordable Care Act didn't outlaw what you're doing, you probably feel like there'd be a lot more of these around the country?

Dr. SMITH. Oh, yes.

The CHAIRMAN. Yes. Dr. Lambrew, what do you think of high-risk pools?

Dr. LAMBREW. You know, there's a fair amount of research on how they operated back then. I looked at Texas's when I was living in Texas, and there was a concern that for people with preexisting

conditions, they would often have to wait months to get into it. They were often getting capped payments so that they would run out of insurance, which is why I think most people who have cancer or work with people who have some sort of disease, much prefer integrating those people into mainstream health insurance.

You know, now, we really have a situation where anybody can get health insurance with a preexisting condition and not worry about whether their coverage will be there for them. The Affordable Care Act has maximum out-of-pocket limits. It makes sure the essential health benefits are covered, and it really makes sure that, hopefully, we all don't need that kind of health insurance. When we need it, it's there.

The CHAIRMAN. Here's actually what's happened since the Affordable Care Act came in to being. The premiums have skyrocketed. Back then a catastrophic plan had a \$5,000 deductible. Most of these ACA plans now have unbelievable deductibles. It's what people didn't want to get, and supposedly the ACA was going to say everybody's going to get all this stuff covered.

Well, now what's happened is premiums are up over 100 percent, copayments are up, deductibles are up. I mean, the deductibles are ridiculously high. Well, here's what's happened with these extended credits. What we're talking—what some people are talking about is these extended credits, the ACA, nothing goes away. Nothing than nobody's losing. You're up to 400 percent—so let me give you an example. If you make—let's see, you can make up to—400 percent would be \$128,000 for a family of four, a couple of 30. Basic, there's almost no change, but you can be worth two million and make \$225,000, and the Federal Government is still subsidizing your healthcare.

The only way we're ever going to get this fixed is we're going to have to start doing what you guys are doing. Number one, we've got to let people buy the insurance they want to buy. Do you want to be told what—how to cover your employees? No. You'd like to say, "For my employees, I'm going to do it this way, and if I don't like it, I'll change it." You can't do that. Right?

Number two, is you ought to—if we are going to help people, like if you want to help your employees, you probably should let them shop. We don't do that. Then, we wonder why healthcare costs have just—they're out of control.

What I like about what you guys are talking about is if we've got to shop for this stuff we do, we're going to get better. We're going to get better price, and Dr. Smith, you said at lunch today, is there a correlation between—and in most businesses, there's a correlation between price and quality? How about healthcare? What do you think?

Dr. SMITH. Well, it's inverse because—

The CHAIRMAN. The opposite what you would think.

Dr. SMITH. It's completely upside down. Yes, if you have so much uncertainty that you can't quote a price, you're probably not very good at what you do, and that's the logic behind it.

The CHAIRMAN. Yes. Well, first of, I want to thank you for—thanks for being here. Thanks for taking all the questions. One thing we're trying to do up here is get everybody more informed about healthcare so we can make better decisions. The healthcare

system that we have created, you would never create. It doesn't work. It costs way too much money. We don't have the outcomes we need. We're spending more than other developed countries with worse outcomes. I mean, in business you would go bankrupt.

If any Senators have additional questions for the witnesses or statements to be added, the hearing record will be open until next Wednesday at 5:00 p.m.

I want to really thank each of you for being here.

[Whereupon, at 5:36 p.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements

U.S. SENATE SPECIAL COMMITTEE ON AGING

"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS"

OCTOBER 22, 2025

PREPARED WITNESS STATEMENTS

Mark Cuban

My Shark Tank companies hate selling on Amazon - but most don't have a choice. About 162 million Americans shop there, and if you want to reach them, you have to play by Amazon's rules.

Amazon knows this and takes full advantage - adding new fees, raising old ones, forcing sellers to buy ads, and even launching copycat products that compete directly with them. They get away with it because they control the marketplace - and because 167 million people pay \$139 a year for Prime, which makes Amazon incredibly "sticky."

So what does that have to do with healthcare?

Insurance companies work the same way. Over 300 million Americans have some kind of coverage - commercial, ACA, Medicare, or Medicaid. Every one of those plans hires a Pharmacy Benefit Manager, or PBM, to run their drug benefits.

Three giant PBMs - all owned by the biggest insurance companies - control pharmacy benefits for about 270 million Americans. That's 70% more people than Amazon reaches.

Like Amazon, PBMs control the "store shelves." Their shelves are called formularies - the lists of drugs your insurance will cover. If a drug isn't on the formulary, it's invisible to doctors and patients.

Here's the kicker: unlike Amazon, which wants lower prices, PBMs actually prefer higher ones.

They say they negotiate lower drug costs - but they don't. They auction off access to their formularies to the highest bidder. Drug companies pay the rebates and fees PBMs demand, so their drugs can be covered and prescribed. If they don't pay, they lose access to millions of patients - costing them billions.

Those rebates and fees are based on a percentage of the drug's list price - called WAC, the Wholesale Acquisition Cost. The higher the list price, the more money PBMs make.

Because PBMs are so powerful, that inflated list price becomes the reference point for the entire drug supply chain.

Take a hypothetical drug - Brand A. The PBM tells the manufacturer to set the list price at \$600, with a 50% rebate and another 10% in fees, leaving the manufacturer with \$240 net.

Now, what does the patient pay?

- If they're uninsured: \$600.
- If they're insured but haven't met their deductible: still \$600.

And yes, the PBM still gets its rebate on that sale. PBMs and the insurance companies that own them love high deductibles because they keep collecting rebates while patients pay full price. Insurance carriers love it even more when patients can't afford their deductibles - because then they never have to pay out from premiums.

So patients end up paying the highest prices of anyone - all because PBMs insist on using inflated list prices instead of transparent net prices.

Meanwhile, wholesalers buy the drug from the manufacturer for \$600. The three major wholesalers all use the same list price, so there's zero price competition, and because their fees are also based on WAC, they profit more when prices rise.

Pharmacies buy from wholesalers at around a 5% discount - about \$570 in this case, but when they fill a brand prescription for an insured patient, they're often reimbursed less than what they paid. They literally lose money on most brand-name drugs, and if they don't fill enough of those money-losing prescriptions, PBMs and wholesalers hit them with even more penalties. No wonder independent pharmacies are being crushed.

Make it make sense. It doesn't.

Because the whole system is built around list prices, everyone - PBMs, wholesalers, and insurers - has an incentive to keep WAC going up, and it almost always does. Patients are the ones who pay the price. And here's the saddest part: self-insured employers, states, and anyone contracting with the big PBMs are signing off

on this system. They approve plans that force patients to pay list price without realizing how badly their members are getting ripped off. We blame PBMs - but the real problem is the people and governments who keep signing these contracts without a clue

And big brand pharma is part of the problem too. They hate the big PBMs, but they let themselves get trapped in this mess with formularies and WAC based pricing.

If they moved to all net pricing, out of pocket prices to patients would drop immediately. There is a reason the USA has the highest brand pricing in the world and it's because we are the only country that uses PBMs.

Coincidence. I think not /)

What to do?

- Require that all cash pays are counted against deductibles
- Require that patient out of pocket costs are based exclusively on net pricing not WAC
- Separate formularies from PBMs
- Use administration leverage to require manufacturers to use net prices and margins rather than list prices and rebate/fees
- Get rid of GCRs and DIRs

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PREPARED WITNESS STATEMENTS

Dr. G. Keith Smith, MD

The Surgery Center of Oklahoma was founded in May of 1997. Our goal was to gain control of the medical and financial treatment of our patients. The problem was that even a minor surgical procedure performed at a large hospital meant bankruptcy for many patients, including insured patients. Consistent with their attempts to maximize revenue, hospitals denied physicians the tools and supplies they thought appropriate to treat their own patients-and yet hospitals continue to book ever increasing profits even today. I have changed this model. Our model is grounded on mutually beneficial exchange. While we save patients tens of thousands of dollars, currently the only ones that walk through our door are patients paying for their own care (about half the population) because if someone else is paying, they don't shop or care how expensive something is.

We were excluded from insurance at the start which meant that we had to be creative. We started quoting patients all-inclusive prices. It was simple math: what fee did the surgeon think was fair, what was the fair anesthesia charge and what was the time and materials based charge for the facility. It turns out that our prices were usually less than the patient's in network deductible and co-pay. Today our total charges are still only 1/6th to 1/10th of what large hospital systems near us charge and even more extreme price discrepancies are routine. In fact, we recently performed a tonsillectomy on a child for \$3875 after the family had been quoted \$72,000 by a Dallas area hospital. Our prices remain half of what Medicare pays hospitals and less than Medicaid payments to hospitals for the same procedure.

The Surgery Center of Oklahoma (www.surgerycenterok.com) quoted prices over the phone to patients until 2009 which is when I launched the first website displaying all-inclusive surgical prices. I had three goals in mind, all of which I would argue have been achieved. First, I wanted sticker-shocked patients to easily find us. Second, I wanted to start a price war, so patients far from Oklahoma could use our pricing as leverage in their local market. Third, I wanted to better understand why the same market discipline other industries must endure was seemingly not a thing in healthcare.

The first patients to arrive after posting our prices were Canadians. These patients are forced to wait in lines longer than the misery they can endure without care. Then it was the uninsured, beneficiaries of self-funded health plans and members of cost-sharing ministries. Approximately half our patients travel from out of state or out of the country to Oklahoma City for their surgical care. As news of the success of our model has grown, so has the number of facilities-and I'm happy to report-large hospitals-who now have copied us.

Price-matching in the industry has had a deflationary effect, even on the price-gouging facilities, as they stand to lose business and patients if they don't compete. Our model also increases the quality of care because physicians with unpredictable outcomes shy away from this tightly disciplined space. The good surgeons would rather perform a surgery at my facility due to better conditions and the higher pay they receive.

While building the surgery center and changing the market, my mission has now grown. I now also run Atlas Billing Company (www.atlasbillingcompany.com) which facilitates payment bundles for the Surgery Center of Oklahoma and is now curating and implementing surgical bundles for many other facilities now attempting to service price-sensitive buyers and patients. I am also a co-founder of the Free Market Medical Association (www.fmma.org), a mission-driven organization that works to bring buyers and sellers together in the United States, promotes market discipline in the industry and now has 37 state chapters.

To the industry big shots, or as I call them the cartel, the healthcare system in this country isn't broken-it is working precisely as designed, meant to enrich the corporate elite and intermediaries at the expense of patients and the American people at large. Fortunately, the alternative approach I've described is becoming more widespread. As insurance deductibles balloon and delays and denials become more commonplace, affordable, high quality care is available for victims of the system. I

predict that "shoppable" medical services will become particularly critical for older Americans as an increasing number of physicians opt out of or severely curtail their exposure to Medicare.
Thank you.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
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OCTOBER 22, 2025

PREPARED WITNESS STATEMENTS

Donald B. Moulds, Ph.D.**Introduction**

Chairman Scott, Ranking Member Gillibrand, and Members of the Committee, thank you for inviting me to testify on behalf of the California Public Employees' Retirement System (CalPERS) and discuss how shoppable services can help control health care costs. I will be using our reference pricing program and other aligned purchasing innovations as case examples.

My name is Don Moulds and I serve as the Chief Health Director for CalPERS. With more than 1.5 million members, CalPERS is the largest commercial health benefits purchaser in California and the second largest commercial purchaser in the nation after the federal government. We contract with numerous large health insurance companies to provide our members with a variety of health plan offerings that include health maintenance, preferred provider, and exclusive provider organization (HMO, PPO, and EPO) plans, as well as Medicare Supplemental and Medicare Advantage (MA) plans. In 2024, we spent over \$12.4 billion purchasing health benefits for active and retired members and their families on behalf of the State of California (including the California State University) and nearly 1,200 public agencies and schools.

In my testimony, I will outline successes and lessons learned from CalPERS' two reference pricing programs: our hip and knee replacement reference pricing program and our Ambulatory Surgery Center Reference Pricing program. I will also describe a new program we instituted last year to incentivize our members to use independent laboratories for shoppable lab services rather than higher cost hospital-based labs. Finally, I will touch on our experience with a price transparency tool.

As I share our experiences, I wish to underscore that there is no "one size fits all" solution for rising health care costs. The cost-driving challenges are multifaceted. So too must be the solutions. We've learned that initially encouraging ideas can have underwhelming results or unintended consequences and that purchasers must be ever vigilant in monitoring and evaluating interventions to ensure they produce the outcomes we are seeking. Having said that, CalPERS considers consumer-oriented incentives, such as reference pricing, to be an integral part of our value-based purchasing model. At the end of my testimony, I will discuss other mechanisms that CalPERS utilizes to provide superior health care services at the greatest value for our members.

About CalPERS

For more than nine decades, CalPERS has provided retirement and health security for state, school, and public agency members serving more than two million members as the nation's largest defined-benefit public pension fund.

As part of our role in administering health benefits for members and their families, CalPERS is committed to ensuring access to equitable, high-quality, affordable health care.

To promote competition and keep premiums affordable, CalPERS regularly commissions competition studies. For example, based on results from the 2021 study, CalPERS implemented health plan service expansions and introduced lower-cost HMO plans. These efforts increase competition within the CalPERS insurance marketplace and put downward price pressure on the premiums, positively impacting CalPERS members and employers.^{1,2}

To control rising health care costs, CalPERS works to align financial incentives with the health plans and Pharmacy Benefit Manager (PBM) we contract with, aiming to mitigate cost trend increases. In June 2024, CalPERS awarded new five-year

¹ See CalPERS, Pension & Health Benefits Committee Agenda Item 7a, available at <https://www.calpers.ca.gov/docs/board-agendas/202103/pension/item-7a—a.pdf>

² See CalPERS, Competition Study & 2022 New Plans, Area Expansion, and Benefit Changes, available at <https://www.calpers.ca.gov/docs/board-agendas/202103/pension/item-7a-attach-2—a.pdf>

contracts for its self-funded PPO plans to Blue Shield of California (BSC) and to Included Health, which serves as the population health management vendors. The contracts are designed to promote savings and improve quality by establishing financial incentives and clinical performance guarantees. BSC and Included Health have committed 64 million at-risk over the term of the contract if they do not meet the program's goals for controlling medical cost trends and improving quality. The contracts set the initial medical trend cost target at 5.5% in 2025, decreasing annually to 3% by 2029. If CalPERS' medical cost trend is lower than the target, BSC and Included Health stand to share in the savings.

In July, CalPERS announced a new five-year pharmacy benefits contract with CVS Caremark (CVS) designed to address rising costs of prescriptions while ensuring access to safe and effective medications for members. Under the agreement, CVS has committed \$250 million at-risk over the term of the contract for controlling drug costs and improving health outcomes. Similar to our HMO and recent PPO contracts, the new PBM contract builds on CalPERS' broader efforts to align health care affordability with quality and equity. By aligning pharmacy benefits with our overall health care goals, CalPERS aims to create a model that can serve as a blueprint for purchasers across the nation.

Reference Based Pricing

CalPERS mitigates medical trend increases through cost and quality conscious strategies, including leveraging curated hospital networks for better pricing, implementing value-based purchasing and integrated health models, fostering competition, and flex-funding. One contributor to increased health care costs is significant price variation for the same service. For example, lab services tend to vary greatly in price, despite no quality difference. Additionally, the prices for procedures provided in hospital outpatient departments are typically higher than those charged in freestanding centers due to the hospitals' higher costs and stronger bargaining position with insurers. In fact, Medicare reimburses hospital-based outpatient procedures at rates substantially higher than those it pays freestanding ambulatory facilities.³ As such, employers and insurers have started to utilize programs encouraging employees and enrollees to select the most cost-effective setting, including reference pricing models, which CalPERS has had success with. In a reference pricing model, the payor sets a maximum price for a specific health care service. Patients still have the option to receive that service at a facility of their choice, but they are responsible for charges above the reference price. This process helps contain costs while maintaining access to quality care by encouraging members to choose a pre-arranged high-quality, lower-cost provider for certain medical services. Patients who require hospital outpatient services due to specific clinical needs or limited local options are not subject to cost-sharing initiatives.

CalPERS Experience #1: Hip and Knee Reference Pricing

In January 2011, CalPERS and Anthem Blue Cross of California (Anthem), our prior third-party administrator for our PPO plans, implemented a reference pricing program for high-cost elective procedures with minimal quality difference among facilities. CalPERS initially aimed to control inpatient hospital orthopedic surgery costs for total hip and total knee replacements. The program involved 46 hospital inpatient facilities statewide that accepted a reference price of \$30,000 and met quality and volume standards. Members who used the designated reference price facilities were responsible for their standard coinsurance payments. However, members who chose a non-designated facility were responsible for any charges above the \$30,000 reference price. Medical exceptions were granted for non-routine procedures, and travel benefits were available for members living over 50 miles from a designated facility. A significant level of effort was devoted to both implementation and member education.

Results: The reference pricing program successfully increased the proportion of members who used designated facilities from about 50% to 64% within two years. Notably, non-reference pricing facilities lowered their charges to match the CalPERS \$30,000 reference price. In turn, price variation for hip and knee replacements decreased dramatically. The average price at preferred facilities dropped from \$35,000 to \$25,500, while the non-reference pricing facilities reduced their prices from \$43,000 to \$27,000.

A study by University of California Berkeley health economists found that CalPERS' reference pricing program saved \$5.5 million in its first two years, with

³See Robinson, James C., Timothy T. Brown and Christopher Whaley. "Reference-Based Benefit Design Changes Consumer Choices and Employers' Payments for Ambulatory Surgery." *Health Affairs* 2015 34:3, 415-422 <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1198>

the average price per procedure declining by 26% or about \$9,000.⁴ Initially, the program sought to create savings through consumer decisions, but market changes and hospital pricing had the biggest impact. We learned anecdotally that non-reference pricing facilities were lowering prices to draw CalPERS members. Berkeley economists concluded that 14% of the savings arose from more individuals selecting reference-based pricing facilities, while 86% were due to cost reduction. Our analysis showed that the program continued to generate approximately \$4 million in annual savings through 2020, with participating facilities expanding from 46 to 72. Additionally, members who utilized reference pricing facilities had lower rates of complications and infections with similar follow-up admission rates. Patient experience was also shown to be better at the reference pricing facilities.

In terms of our overall health care spend, savings from reference pricing have been relatively modest, but the model has nonetheless offered valuable insights and lessons that may inform future strategies and potentially yield further savings.

- More member outreach could have been beneficial, such as phone calls or letters to members who had been referred to a procedure that could have been done at an ASC or a pop-up in the price transparency tool when members searched for a reference pricing procedure.

- Our reference price has applied only to the facility portion of the procedure and excluded professional fees and other related costs. Adopting a bundled payment approach alongside reference pricing could be beneficial.

- CalPERS has used a single statewide price that is easily communicated to members, despite significant price variation by region, with Northern California historically much more expensive than Southern California. Cost savings could be improved with regional pricing, but it might be more difficult to explain to our members.

CalPERS Experience #2: Ambulatory Surgery Center Reference Pricing

In 2012, CalPERS and Anthem introduced a second reference pricing program for Colonoscopy, Cataract and Arthroscopy services. Under this program, procedures not performed at an Ambulatory Surgery Center (ASC) have a set reference price. Similar to the hip and knee replacement procedures, we identified large price variations for colonoscopy, cataract, and arthroscopy services. The variation mainly depended on the location of care, specifically whether procedures were provided by Hospital Outpatient Facilities vs. ASCs. We noticed a substantial increase in routine non-screening colonoscopies at ASCs, climbing from 70% to over 90%. In contrast, Anthem's broader business had around 75% of these procedures at ASCs.

Results: The University of California, Berkeley's evaluation of this program showed total savings of \$5 million each year and realized average reductions of 21%. Specifically, cataract surgeries resulted in \$1.3 million in savings (20% reduction), colonoscopies saved \$7 million (28% reduction), and arthroscopies contributed \$2.3 million (17% reduction) across a two-year timeframe.^{5,6} As a result, in 2018, CalPERS extended its ASC reference pricing program to 12 additional procedures, including endoscopic and laparoscopic procedures.

CalPERS Experience #3: Member Incentive Lab Program

In 2024, CalPERS implemented a member incentive program for labs due to high price variation with no quality difference. National research shows that lab services in hospitals (e.g., large health systems) cost roughly 3.7 times more than those at independent labs.⁷ Our data indicates the markup may be even higher, especially compared with California's two largest independent lab providers.

Our program offers no cost sharing for preferred independent labs in California, but non-preferred labs require standard coinsurance. In contrast to the other ref-

⁴ See Robinson, James C., and Timothy T. Brown. "Increases in consumer cost sharing redirect patient volumes and reduce hospital prices for orthopedic surgery." at Health Affairs 32.8 (2013): 1392-1397. <https://doi.org/10.1377/hlthaff.2013.0188>

⁵ See Robinson, James C., Timothy T. Brown and Christopher Whaley. "Reference-Based Benefit Design Changes Consumer Choices and Employers' Payments for Ambulatory Surgery." Health Affairs 2015 34:3, 415-422 <https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1198>

⁶ See Robinson, James C, Timothy T. Brown and Christopher Whaley. "Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications." JAMA Internal Medicine 2015;175;(11):1783-1789. <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/243473>

⁷ See Chang, Jessica, Katie Martin, Yuvraj Pathak and Marissa Myers. "Price Markups for Clinical Labs: Employer based Insurance Pays Hospital Outpatient Departments 3X Than Physician Offices and Independent Labs for Identical Tests." Health Care Cost Institute, <https://healthcostinstitute.org/images/pdfs/HCCI%20Lab%20Brief-103124.pdf>

erence pricing programs, the lab incentive program provides financial incentives for our members to choose the lower-cost option without imposing additional costs for those who opt out.

While we are still evaluating this program, preliminary results indicate it increased preferred lab use by 4% and saved members \$2.4 million in its first year. As a result, we are expanding outreach to improve awareness of the program and encourage more use of the preferred lab sites.

CalPERS Experience #4: Price transparency tool

To aid price shopping, CalPERS provided a price transparency tool for PPO members in 2014 that allowed members to use an app to search for location, price, and quality of services. The tool was created to empower members to shop for services based on both price and quality, fostering greater member engagement. When paired with reference pricing, the goal was to create a more informed and engaged member.

Results: Ultimately, the price transparency tool fell short of delivering expected overall cost savings. Members saved on imaging costs, but spending in other 'shoppable' categories and reference pricing procedures showed no decrease.

We found that few of our members used the tool, especially for price shopping. Even though 24% of CalPERS households registered to use the tool, only 12% used it to search prices, and just 4% maintained usage (3 or more times, at least 90 days apart). Our experience is consistent with other research in this area.⁸ A small fraction of people sign up for these tools, and among those who sign up, few use the tool before seeking care. Furthermore, when they do use the tool to search prices, for most services, users do not choose a lower cost provider.

As such, CalPERS stopped offering the tool after 2.5 years due to the added cost of the tool. We found that there are a limited range of services that are truly 'shoppable' and that our benefits with low cost sharing diminished the relevance of price shopping for most services. While members express an interest in quality and pricing, their decisions frequently hinge on the referrals they receive from healthcare providers.⁹ Additionally, rural communities lacked sufficient options to facilitate a meaningful comparison.

Limitations on Reference Based Pricing

Reference based pricing has shown promise, but it is not a panacea. Research suggests that if implemented as broadly as possible, it saves about five percent of total cost of care.¹⁰ Considering that CalPERS spends approximately \$2.3 billion each year (or \$6.4 million per day) on the affected PPO population, the savings are quite modest.

Overall savings are limited by the small number of procedures where reference pricing makes sense. While reference pricing is well suited for non-emergent elective procedures with significant price differences, many healthcare services are not "shoppable."

Our experience has shown that while price referencing programs can work, to truly manage rising health care costs, other issues need to be addressed, including:

- **Competition:** CalPERS has found that insufficient competition results in higher prices. Since 2010, competition among hospitals and providers in California has lessened, notably in rural regions.^{11,12} As of 2018, 52% of specialists and 42% of primary care physicians were in health system-owned practices.¹³ In markets

⁸Desai S, Hatfield LA, Hicks AL, Chernew ME, Mehrotra A. Association Between Availability of a Price Transparency Tool and Outpatient Spending. *JAMA*. 2016;315(17):1874-1881. doi:10.1001/jama.2016.4288

⁹Semigran, H., Gourevitch, R., Sinaiko, A., Cowling, D., & Mehrotra, A. (2018). Patients' views on price shopping and price transparency. *The American journal of managed care*, 23(6), e186e192-ee192. Available at: <https://pubmed.ncbi.nlm.nih.gov/28817296/>

¹⁰White, Chapin, and Megan Eguchi. Reference Pricing: A Small Piece of Health Care Price and Quality Puzzle. National Institute for Health Care Reform. Available at: <https://nihcr.org/wp-content/uploads/2016/07/Research—Brief—No.—18.pdf>

¹¹See California Health Care Foundation (CHCF), *The Sky's the Limit: Health Care Prices and Market Consolidation in California*, available at <https://www.chcf.org/wp-content/uploads/2019/09/SkysLimitPricesMarketConsolidation.pdf>

¹²See California Health Care Foundation (CHCF), *Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California*, available at <https://www.chcf.org/publication/markets-monopolies-health-care-consolidation-california/>

¹³Ibid.

with fewer hospitals, consolidation led to a 12% increase in premiums, a 9% rise in specialist fees, and a 5% rise in primary care costs from 2013 to 2016.¹⁴

- To address abuses in this space, Congress could pass laws to stop anti-competitive practices in contracts between providers and health plans. Specifically, we support the passage of the Healthy Competition for Better Care Act (S. 1451), which encourages a more open market, fosters competition, drives innovation, improves quality, and reduces costs.

- Transparency: We see transparency as vital in developing shoppable services but emphasize that it should be user-friendly for all stakeholders. CalPERS maintains a comprehensive claims data warehouse to track health care costs and outcomes, allowing us to identify cost drivers and innovate in areas like reference pricing. Other payers may lack this long-term data, making federal standards for hospital transparency crucial. We commend the Administration's efforts to ensure comprehensive and precise reporting of hospital price data.

- Innovation: Beyond reference pricing, CalPERS continuously explores innovative approaches to reduce costs and improve quality. For example, CalPERS, in alignment with other large public purchaser partners in California, adopted a subset of quality and outcome measures and tied significant financial accountability to high-performance on these measures for our health plans. These measures, known as the Quality Alignment Measure Set (QAMS), and the financial incentives tied to them, aim to improve care for clinically important conditions for which there are major opportunities for improvement and evidence-based measures in current use. The QAMS consists of five measures, all of which are nationally endorsed, evidence-based NCQA HEDIS measures: Childhood Immunizations, Controlling High Blood Pressure, Comprehensive Diabetes Care - Poor Control (HgbA1c >9 percent), Colorectal Cancer Screening, Maternity Care (reflecting a combined score for Timeliness of Prenatal Care and Postpartum Care).

Conclusion

Thank you, again, for inviting me to participate in today's hearing. CalPERS' application of Reference Pricing models demonstrates modest but notable savings in shoppable services. However, truly curbing rising health care costs requires a thoughtful, multi-faceted approach. CalPERS is uniquely positioned to assist the Committee as it develops policy and I welcome your questions on how we manage health care costs.

¹⁴ See Health Affairs, Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices, available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472>

U.S. SENATE SPECIAL COMMITTEE ON AGING
"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS"

OCTOBER 22, 2025

PREPARED WITNESS STATEMENTS

Dr. Jeanne Lambrew, Ph.D.

**Testimony of Jeanne M. Lambrew, Ph.D.
Director, Health Care Reform and Senior Fellow
The Century Foundation**

Before the U. S. Senate Special Committee on Aging

Hearing Entitled:

Modernizing Health Care: How Shoppable Services Improve Outcomes and Lower Costs

October 22, 2025

Chairman Scott, Ranking Member Gillibrand, and distinguished members of the Committee, thank you for the opportunity to testify on health care shopping and its impact on costs and outcomes.

My name is Jeanne Lambrew. I am director of health care reform and a senior fellow at the Century Foundation, an independent think tank that conducts research, develops solutions, and drives policy change to make people's lives better. I am also an adjunct professor of health policy at the T.H. Chan Harvard School of Public Health. Prior to these positions, I was commissioner of the Maine Department of Health and Human Services when the state expanded Medicaid and established a state-based Marketplace. I also served in the U.S. Department of Health and Human Services and White House. I have experience in federal and state policies related to private insurance, Medicaid, Medicare, and public health.

Background

Shopping for affordable medications and high-quality services matters. So does shopping for health plans. When designed well, health plans pool purchasing power to give enrollees access to high-quality, low-cost services. They also pool risk through premiums to pay for health care if and when enrollees need it. Additionally, with few exceptions, private health plans limit annual out-of-pocket costs, ensure minimum levels of coverage, and fully pay for proven preventive services – thanks to reforms in the Affordable Care Act (ACA).

Health Insurance Marketplaces. In addition to private insurance reforms, the ACA created a shopping platform for people buying private plans on their own called health insurance marketplaces. Marketplaces offer health plans in tiers from bronze to platinum based on the percent of expected costs they cover. Shoppers can check to see if a plan includes their doctors or drugs. They can also compare plans based on their monthly premiums, deductibles, and other features. While the federal government runs [HealthCare.gov](https://www.healthcare.gov) for thirty-one states, twenty states offer their own marketplaces—[more than half](#) of which have recently opened up window

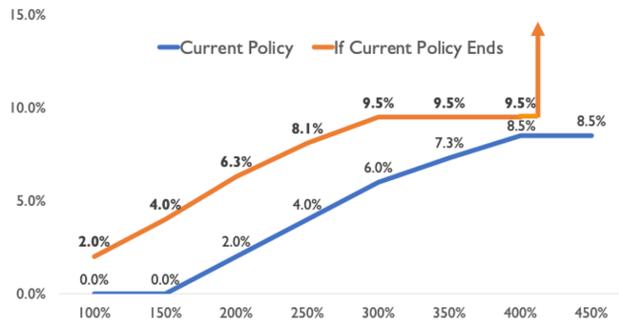
shopping for 2026 plans. Marketplaces are funded by user fees from participating insurance companies.

Premium Tax Credits. This shopping experience is enhanced by premium tax credits for people with income above the poverty level who lack access to affordable employer-based coverage. The credits are [set](#) competitively, based on the second lowest silver-plan premium in an area called the benchmark. Currently, under changes made in 2021 that end in 2025, eligible enrollees' payment for the benchmark plan is limited to 8.5 percent of their income, with the tax credit paying for the rest. The current tax credit automatically phases out as income rises. People with income below 400 percent of the poverty level pay a lower percent of their income for premiums (Figure 1). Once set, the tax credit is like a voucher: with it, enrollees can choose more or less generous coverage.

FIGURE 1.

OUT-OF-POCKET SHARE OF PREMIUMS WILL CLIMB IF CURRENT POLICY ENDS

Limits on family share of ACA marketplace premiums for 2026



Sources: Current law; Patzman, Andrew, Strong, Kendall, and Harootunian, Lisa. "Enhanced Premium Tax Credits: Who Benefits, How Much, and What Happens Next?" Bipartisan Policy Center. October 15, 2025.

Recent Performance

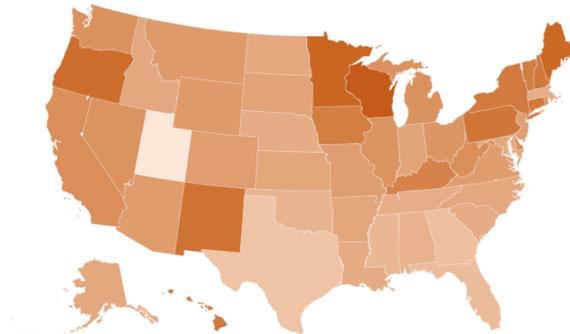
Overall Enrollment and Health Coverage. Currently, [24 million people](#) are covered through health insurance marketplaces, double the number enrolled in 2020 and triple the number enrolled in 2014. The marketplace growth contributed to [record-low uninsured rates](#) in 2022, 2023, and 2024. About half of these people are [small business owners, workers, or self-employed](#). In sixteen states, a higher percentage of [rural](#) residents than urban residents are enrolled in marketplace coverage. Over half of marketplace enrollees live in states that have [not implemented the ACA Medicaid expansion](#) compared to only 28 percent of the U.S. population. Over [600,000](#) are Veterans. The [diversity](#) of marketplace enrollees also increased since 2020.

Enrollment and Health Coverage of Older Americans. Marketplace enrollees are older than the overall non-elderly population, with [23 percent of enrollees](#) being aged 55 to 64 compared to [15 percent](#) in the general population. The share of older enrollees is 30 percent or higher in eleven states (Figure 2). About 5.5 million marketplace enrollees are ages 50 to 64 (eligibility for the marketplace ends when Medicare begins). [Nearly one in ten](#) older Americans relies on coverage purchased on their own. An AARP analysis estimates that marketplace and other ACA reforms reduced the uninsured rate among people ages 50 to 64 by [50 percent](#).

FIGURE 2.

ACA ENROLLEES ARE OLDER

More than 30% of marketplace enrollees are ages 55 to 64 in eleven states



Source: Author's calculation based on KFF State Health Facts, 2025 Plan Selections by Age.



Choice. Choices in the marketplace have increased. In [2025](#), 97 percent of enrollees in states using the federal marketplace, HealthCare.gov, had three or more insurance companies offering plans, up from 68 percent in 2020. Similarly, the number of health plan choices per county averages 99.5, up from 38.5 plans in 2020. Starting in 2023, HealthCare.gov required insurers to offer [standard cost sharing](#) plans in some but not all of their plans, enabling consumers to shop based on premiums and networks rather than deductibles and copays.

Costs. From 2020 to 2025, marketplace benchmark premiums increased by an average annual rate of [2 percent](#), slower than [employer-sponsored insurance](#) and [inflation](#), both of which were around 5 percent. [Studies](#) have [repeatedly](#) found that competition among marketplace plans has led to lower premiums. Competition may also help explain why fully insured plans like those in the marketplace have [lower provider payment rates](#) than self-funded health plans. It is also noteworthy that, according to one [analysis](#), median individual deductibles dropped by almost half, from \$750 to \$400, between 2021 and 2023.

Changes

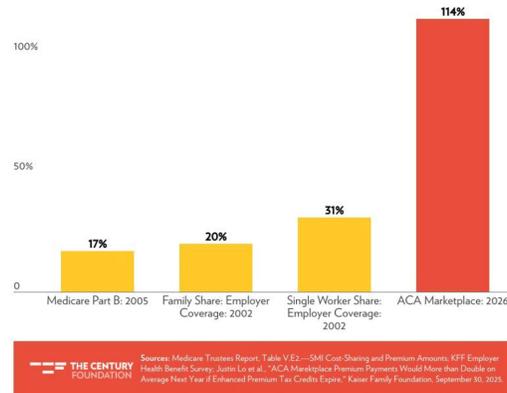
Overall Impact on Marketplace Enrollees. All this is about to change. The [budget reconciliation law](#) erected barriers to getting and staying covered in the marketplace, which will worsen the risk pool and increase the number of uninsured. Trump administration [rule changes](#) will lower premium tax credits and raise out-of-pocket limits, among other changes. And, even though dozens of expiring tax cuts were extended in the budget law, current levels of premium tax credits were not. Since 2021, the value of the tax credits has been [enhanced](#) and the extra cap on premium tax credits was lifted, allowing the tax credit to phase out with income rather than ending abruptly when income increases over 400 percent of the poverty level. Combining these effects, the Congressional Budget Office estimates [7 million people](#) who would otherwise have been in the marketplace will become uninsured by 2034. Based on its projections for the same year, federal funding for premium tax credits will be 46 percent below baseline.

But the harm begins this coming year. Premiums are already locked in for 2026. People in Idaho have started signing up for coverage and people in all states will start doing so on November 1. Without Congressional action to extend current tax credits, shoppers will experience sticker shock when newly signing up for or renewing marketplace health coverage.

Health Insurance Premium Increases

Average Premium Increase. The average marketplace enrollee will pay [more than twice as much](#) for premiums starting in January, with many paying much more. There is [no historical precedent](#) for such a large one-year increase in premiums for so many Americans (Figure 3).

FIGURE 3.

ACA PREMIUM INCREASES LARGEST RECORDED*Share paid by enrollees in ACA to double*

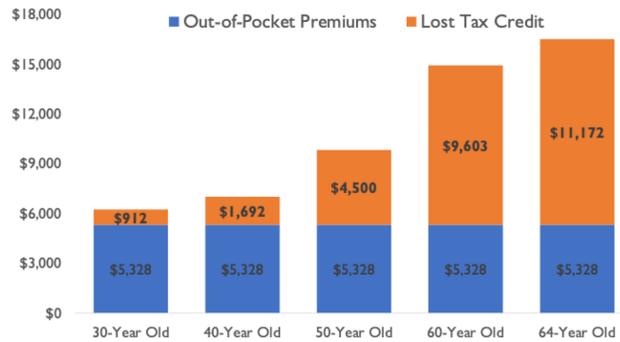
Older Americans’ Premiums Increase. Many enrollees will pay significantly more than the average increase of [\\$1,016](#) due to family size, income, location—and age. Insurers can charge older people more than younger people. A sixty-year old couple with income of \$50,000 (236% of the federal poverty level) would pay [\\$2,240](#) more annually for the benchmark plan.

Moreover, older Americans will be much more affected by reinstating the cut-off of premium tax credits for people with income above 400 percent of the federal poverty level (which translates into \$62,600 for a single person and \$128,600 for a family of four this year) (Figure 4). [Over half](#) of all people who will lose tax credit eligibility altogether in January are ages 50 to 64. If that same sixty year old couple has income of \$85,000 (402 percent of the federal poverty level), the average increase would be [\\$22,635 more](#) in 2026 for a benchmark plan. This couple would pay 27 percent rather than 8.5 percent of their household income for premiums.

FIGURE 4.

OLDER ACA ENROLLES AT GREATEST RISK

Average out-of-pocket premiums in 2026 for a single person with income of \$62,700



Note: Author's calculation based on: McGough, Matt. "Quick Takes: If Enhanced ACA Tax Credits Expire, Older Marketplace Enrollees Face Steepest Premium Hikes" Kaiser Family Foundation. Oct. 6, 2025.

Regional Variation in Older Americans' Premiums Increase. The increase in out-of-pocket premiums for older marketplace enrollees will vary by location. Early window shopping for 2026 plans (Figure 5) shows that a 60-year old couple earning \$85,000 will pay annually for a benchmark plan:

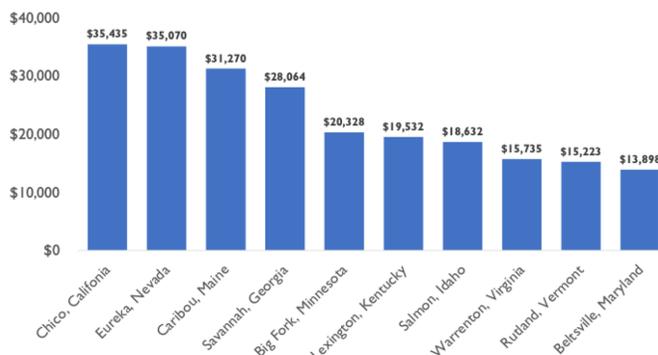
- \$28,064 more in Savannah, Georgia;
- \$18,632 more in Salmon, Idaho; and
- \$13,899 more in Beltsville, Maryland.

My home state of Maine, which is on many metrics the older state in the nation, will be particularly hard hit because of its residents' age, health system consolidation, and rurality.

FIGURE 5.

OLDER COUPLES MAY PAY > \$10,000 MORE

Actual 2026 annual out-of-pocket premium increase for a 60-year old couple with income of \$85,000



Sources: Author's calculation based on state-based marketplace websites: second-lowest silver plan.

Potential Impact on Older Americans

Retirement Security. Older people have relatively high health needs. As such, they are more likely to pay the extremely high marketplace premium increases to stay insured. Absorbing such large premium increases would likely cut into household budgets for basic necessities. For example, if the 60-year old couple paid the average increase of [\\$22,635](#) until they enrolled in Medicare at age 65, this could cost them over 60 percent of the median lifetime retirement savings of people ages 55 to 64 of [\\$185,000](#).

Access and Health. Other older marketplace enrollees will simply be unable to afford the premium hikes and will become uninsured. Lacking coverage is [associated](#) with lower use of needed health care. Studies also have found being uninsured increases a person's risk of [mortality](#). Simply stated, the older people losing health coverage because of the reduced tax credits are at greater risk of unmet needs, worse health, and preventable death.

Medicare Costs. Uninsurance among people ages 55 to 64 also affects Medicare. Research suggests that people who were uninsured prior to enrolling in Medicare have higher [needs](#) and [significantly higher costs](#) than those who were previously insured.

In Their Own Words

Current marketplace enrollees have described what the change will mean for them. For example:

- [Tracy W., a 57-year-old from Georgia](#): “That amount may not seem like much to the government or to the insurance companies, but for me it would most likely mean sacrificing essentials: groceries, gas, basic necessities that I rely on.”
- [Michael, a 54-year-old from Arizona](#): “If it does happen, we’ll have to cut costs elsewhere and that’s now digging into basic necessities, like, food, car, gas, rent. We’re struggling already as it is.”
- [Charlene, a 60-year old from New York](#): “When you take away this extra help, even if it’s \$5 a month, that’s still \$5 a month, because your electric bill goes up \$14 a month. People can’t afford it.”
- [Kristen, a retired teacher from Maine](#): “If these health care tax credits are allowed to expire, many families will face impossible choices. People like me, caregivers, parents, those living with chronic illness, will be forced to decide between paying for their own care or covering a loved one’s. Some will go into debt. Others will delay or skip essential treatment. Either way, the cost isn’t just money — it’s worse health, more stress and a system that lets people down when they need it most.”

Potential Impact on All Americans

Market Stability and Choice. The significant impact of reduced tax credits on premiums and enrollment will affect the stability, affordability, and accessibility of the individual insurance market for people purchasing on their own without tax credits. As a result of not extending the tax credits, Marketplace enrollment next year is [projected](#) to drop by over 30 percent nationally and by more than 50 percent in Georgia, Louisiana, Mississippi, Oregon, South Carolina, Tennessee, Texas, and West Virginia. This, along with concerns about fewer consumer choices, is why the bipartisan [National Association of Insurance Commissioners](#) has urged extension of the premium tax credits.

Health System Capacity. The impact of older people losing health coverage will extend to all Americans’ access to health services. In the words of the [American Hospital Association](#), “This

loss of coverage would put considerable stress on hospitals and health systems, which will experience more uncompensated care and bad debt. There will also be an impact on the entire community, even those with coverage, because of an influx of uninsured patients into emergency departments causing longer waits, stress on the whole health care system and the inability to get the care they need.”

Jobs and the Economy. There could also be an effect on jobs and the economy. A recent analysis [estimates](#) that 339,000 jobs could be lost, and state and local revenue could drop by \$2.5 billion, due to failure to continue tax credits.

What’s On the Horizon for Older Americans: Medicaid Changes

This testimony has focused on the ACA marketplaces and premium tax credits because of its time sensitivity. However, in the coming years, changes to the Medicaid program in the budget reconciliation law will also have profound effects on older Americans’ access to health care, including those over age 65 (e.g., new asset test for nursing home care; continued obstacles to enrolling in Medicare Savings Programs). A few of the policies affecting those ages 50 to 64 are described below.

Medicaid Work Requirements. According to [KFF](#), older Medicaid enrollees may be most at risk of losing coverage due to work requirements starting in January 2027. The percent of non-disabled, non-parent adults with Medicaid coverage that are employed or in school is 72 percent of enrollees ages 19 to 27, 66 percent of enrollees ages 27 to 49, but less than half (48%) of enrollees ages 50 to 64.

Required Eligibility Checks Twice a Year. Also starting in January 2027, people covered through the ACA’s Medicaid expansion will need to have their eligibility checked every six months which will result in [over \\$60 billion](#) in savings over the next decade due to coverage loss, according to the Congressional Budget Office. Approximately [6 million](#) older people are covered through the Medicaid expansion.

New Cost Sharing for Medicaid Expansion Enrollees. Starting in October 2028, Medicaid expansion enrollees with income above 100 percent of the federal poverty level may have to pay up to \$35 copays for certain health services. Generally, people ages 55 to 64 have health costs that are [three times higher](#) than those of adults ages 18 to 24. As such, older Medicaid expansion enrollees will likely disproportionately pay more or forego care due to this policy. This, along with reduced coverage in the marketplaces, will likely increase medical debt.

Conclusion

American people want clear choices and affordable options when it comes to health care and coverage. The policies and proposals being considered by this Committee may offer them that.

However, one proposal—extending tax breaks for private insurance—is at the forefront of the debate and merits attention as well as bipartisan support. It is straight out of a traditional conservative’s playbook. It expands private coverage, leverages the tax code, and sets the amount of federal assistance through private plan competition. It requires no new government workers or bureaucracy to implement. And it reduces uncompensated care for hospitals, doctors, clinics, and other providers. It also meets progressives’ goals of supporting coverage that provides meaningful benefits, limited cost sharing, and income-related premium support. ACA plans provide peace of mind to people with pre-existing conditions and their families. While improvements to ACA plans can and should be made, marketplace tax credits as currently designed have proven they can work and they should be extended.

Thank you for the opportunity to present this testimony.

Questions for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS"

OCTOBER 22, 2025

QUESTIONS FOR THE RECORD

Mark Cuban**Senator Mark Kelly****Question:**

You have pushed for greater transparency and fairness in prescription drug pricing. Many Americans, including seniors on fixed incomes, continue to struggle with rising drug costs despite recent reforms.

As new drug pricing models and federal policies take shape, there is concern about how these changes will affect the stability of supply and the ability of smaller providers and rural hospitals to keep essential medicines in stock. We all agree that prescription drug costs are too high, but in states like Arizona, many people rely on Medicare and Medicaid. So even small pricing shifts could have ripple effects on access and affordability, especially for small hospitals, community pharmacies, and rural clinics.

How can future pricing models and market changes avoid unintentionally raising costs or limiting access for patients who rely on public programs or small community providers?

Response:

The solution is for states to stop working with industry behemoths and instead join together to create their own group purchasing organizations (GPOs). These state-run GPOs could purchase everything from generic and brand medications to medical equipment. Their aggregate buying power would shift pricing and availability leverage away from PBMs, wholesalers, and insurance companies and move it directly to the states."

Question:

How can we encourage transparency and competition in the drug market while maintaining a reliable supply of medicines for seniors and people with chronic conditions?

Response:

If states work together to purchase all medications, from the cheapest generics to the most expensive therapies, they can use their combined volume to require that all purchases are made at a net price. This model would also require all associated costs, markups, and prices to be published, ensuring full transparency and removing any question about whether the pricing is fair."

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QUESTIONS FOR THE RECORD

Dr. G. Keith Smith, MD**Senator Mark Kelly****Question:**

It's clear that transparent, all-inclusive pricing has allowed patients to save tens of thousands of dollars.

At the same time, many older Americans, particularly those in rural or lower-income areas, still struggle to access care because of high hospital costs and reduced Medicaid reimbursement rates.

For transparency to work, it also has to be fair and accessible to patients on Medicare and Medicaid. This is also important for those in rural areas who may not have multiple provider options, which makes it hard to make informed decisions about their care.

How can we expand shoppable health care so that patients in places like rural Arizona can actually benefit from transparent pricing and consumer choice, rather than seeing these reforms limited to larger or urban health systems?

Response:

Thank you for your question. While certain, high-complexity services can only be delivered in high population areas due to specialization of personnel and equipment, primary care, imaging, simple surgical and obstetrical care can be delivered in rural areas and has been traditionally. My great uncle, Walter Bayes, owned the only hospital in Chickasha, Oklahoma (some of the old-timers still talk about Bayes Hospital). His ownership and control of the facility allowed him to treat patients as individuals, both medically and financially. Most of the rural hospitals in Oklahoma (and I'd bet nationally) were established, owned and controlled by the physicians working in the small towns. I would suggest that just as my surgery center is owned and controlled by the physicians working there, physician ownership of rural hospitals (currently prohibited by Stark laws) would solve part one of rural health care's issue: supply. Ownership would not only powerfully recruit new graduates from residency, it would almost certainly draw urban physicians, disgruntled with their job as a hospital employee or otherwise grinding out a living in a corporate atmosphere. Demand, is part two of rural health care's issue, fueled by relieving patients of a large part of their out of pocket expense. Medicare price controls have not only caused shortages on the supply side, but, relieved of so much of their out of pocket expense, the demand side by patients without sticker shock has overwhelmed the restricted supply of personnel and services. I would suggest that allowing physicians to own the hospitals and repealing balance billing provisions which currently restrict physician fees to the "Medicare allowable" would together bring more market discipline to rural care. Any physician inclined to abuse patients with this new freedom would find their waiting room empty as more arriving competitors would keep this temptation in check. I hope this answer is helpful to you and in line with your inquiry.

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QUESTIONS FOR THE RECORD

Dr. Don Moulds, Ph.D.Senator Raphael Warnock**Question:**

According to a [KFF survey](#), family premiums for employer-sponsored health insurance increased by 6 percent in 2025 compared to the previous year, citing increases in hospital prices, among other factors. Costs are only expected to continue increasing, with the upcoming expiration of the Affordable Care Act (ACA) premium tax credits and Medicaid cuts from H.R.

How will cuts to ACA and Medicaid increase hospital prices across the board?

Response:

The full impact from these cuts is still unknown. We do know that comprehensive insurance coverage and access to preventive services are crucial to developing and maintaining a stable, cost-effective health care system. When people lack insurance, health care costs do not disappear – they shift to hospitals, who provide necessary care to uninsured patients, as required by law. Hospitals often cite the costs of this uncompensated care when negotiating higher rates with commercial health insurers. This shift is exacerbated by limited access to preventive services, further driving up health care expenses. Coverage gaps destabilize existing health care infrastructure, eroding quality and access to care for everyone.

The stakes are particularly high in California. Medi-Cal, California's Medicaid program, covers nearly 15 million people, more than one-third of the state's population and half of all children.¹ Funding cuts are particularly detrimental to the stability of financially imperiled hospitals in rural and inner-city areas. More than half of California residents in rural areas rely on Medi-Cal as their primary source of health coverage. Beyond Medi-Cal, more than 1.7 million Californians depend on federal subsidies to afford exchange-based insurance premiums.² An estimated 400,000 Californians will become uninsured due to the expiration of the subsidies.³ When people lack access, they often delay needed care, stretch out their medications, and forgo important preventive screenings. This leads to a higher-acuity and overall sicker population. Undermining the financial viability of health care programs reduces the number of insured Californians and increases costs for everyone, including those with employer-sponsored and commercial coverage.

¹ California Department of Health Care Services (2025, March). Medi-Cal Monthly Eligible Fast Facts (Data Represented: December 2024).

<https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFactsDecember2024.pdf>.

² Kaiser Family Foundation. Estimated Total Premium Tax Credits Received by Marketplace Enrollees. Retrieved November 7, 2025, from <https://www.kff.org/affordable-care-act/state-indicator/average-monthly-advance-premium-tax-credit->

[apc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/affordable-care-act/state-indicator/average-monthly-advance-premium-tax-credit-?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

³ ABC News. (2025, November). Estimated 400K Californians could be 'priced out' of Covered CA if Congress doesn't extend funding. <https://abc7news.com/post/estimated-400k-californians-could-priced-covered-ca-congress-doesnt-extend-funding/18140716/>.

Senator Mark Kelly**Question:**

Public programs and large purchasers like CalPERS have been national leaders in driving cost control. Your experience shows that transparency only works when paired with accountability and incentives.

In Arizona and across the country, rising costs continue to strain both families and state health systems, even as we work to modernize programs. Public payers like Medicaid and the state employee health plan face a lot of cost pressures.

How can public payers ensure that modernization translates into real savings and better care for patients, rather than just shifting costs within the system?

Response:

Due to our size, CalPERS has been able to negotiate favorable terms in our contracts with health insurers and Pharmacy Benefit Managers (PBMs) to maximize savings, including caps on administrative costs and profits, total cost of care guarantees, financial alignment on key health care quality measures, cost transparency, and more. Despite this, our costs remain high. No single purchaser, no matter how large, can overcome the systemic drivers of rising health care costs alone. We need federal reforms that apply across the entire health care system, including commercial markets, and not just Medicare or Medicaid. There are several critical areas where Congress could help reduce costs in health care:

- **Health Care Consolidation:** CalPERS faces significant cost pressures resulting from health care consolidation, mirroring a national trend. Reduced competition drives higher prices across the board. Since 2010, hospital and provider competition in California has declined sharply, particularly in rural regions.⁴ As of 2018, health system-owned practices had absorbed 52% of specialists and 42% of primary care physicians.⁵ The financial consequences are significant: between 2013 and 2016, markets with reduced hospital competition experienced a 12% increase in premiums, a 9% rise in specialist fees, and a 5% increase in primary care costs.⁶

⁴ Fulton BD. (2017, September) Health Care Market Concentration Trends in the United States: Evidence and Policy Responses. Health Affairs. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0556#:~:text=The%20Council%20of%20Economic%20Advisers,entry%2C%20and%20restricting%20anticompetitive%20behaviors>.

⁵ California Health Care Foundation (2021, December). Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California. <https://www.chcf.org/wp-content/uploads/2021/11/MarketsMonopoliesHCConsolidation.pdf>

⁶ Scheffler RM, Arnold DR, Whaley CM. (2018, September) Consolidation Trends in California's Health Care System:

We urge Congress to pass legislation to strengthen federal oversight of health care mergers and acquisitions. Specifically, CalPERS encourages the Department of Justice and the Federal Trade Commission to increase transparency and information reporting regarding potentially anticompetitive transactions. Additionally, CalPERS supports the provisions from last session's Healthy Competition for Better Care Act (S. 1451 / H.R. 3120) from the last Congress, which would promote market openness, foster competition, drive innovation, improve quality, and reduce costs.

- **Price Transparency:** CalPERS supports the transparency provisions contained in last session's Lower Costs, More Transparency Act ([H.R. 5378](#)), and this session's Patients Deserve Price Tags Act ([H.R. 5582/S. 2355](#)). Both bills would codify hospital and plan price transparency rules and expand requirements to include hospitals, labs, imaging centers, and ambulatory surgical centers. While both advance transparency, the Patients Deserve Price Tags Act is more prescriptive, consumer-focused, and includes enforcement mechanisms. Additionally, both bills contain Pharmacy Benefit Manager (PBM) transparency provisions, requiring PBMs to disclose data on drug pricing, rebates, and compensation. Collectively, these changes would provide purchasers with critical information to help control costs and empower consumers to make better informed choices about their health care.
- **Prescription Drug Pricing:** In 2024, outpatient prescription drugs accounted for approximately 20% of CalPERS' \$12.4 billion health care expenditure – nearly \$2.4 billion.⁷ CalPERS supports policies that accelerate generic and biosimilar drug market entry and increase competition. Specifically, we urge passage of last session's Affordable Prescription for Patients Act ([S.1041](#)), which passed the Senate in the last Congress. S.1041 would limit the number of patents a drug manufacturer can assert, thereby curbing patent thickets. We also support the Stop STALLING Act ([S. 1095](#)), which would restrict sham citizen petitions that delay the Food and Drug Administration's drug approval process, and the Preserve Access to Affordable Generics and Biosimilars Act ([S. 1096](#)), which would limit "pay-for-delay" schemes used by brand name drug manufacturers that keep lower-cost alternatives off the market.

Impacts on ACA Premiums and Outpatient Visit Prices. Health Affairs.

<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0472#:~:text=For%20physician%20outpatient%20services%2C%20the%20other%20regulatory%20changes%20are%20suggested.>

⁷ California Public Employees' Retirement System. (2025, November). Health Benefits Program, 2024 Annual Report. <https://www.calpers.ca.gov/documents/health-benefits-program-annual-report-2025/download?inline>

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QUESTIONS FOR THE RECORD

Dr. Jeanne Lambrew, Ph.D.**Senator Raphael Warnock****Question:**

According to Justice in Aging, 1 in 5 Americans between the ages of 50 to 64 are enrolled in Medicaid, with 5 million of those individuals covered through Medicaid expansion. Older adults also face challenges with employment, something that the Special Committee on Aging examined just last month.

How will older Americans face barriers to health coverage under H.R. 1's new Medicaid work requirements?

Response:

According to KFF, older Medicaid enrollees may be most at risk of losing coverage due to work requirements that begin in January 2027. The percent of non-disabled, non-parent adults with Medicaid coverage that are employed or in school is 72 percent of those ages 19 to 27, 66 percent of those ages 27 to 49, but less than half (48%) of enrollees ages 50 to 64.

In addition to its new work requirements, H.R. 1 makes other changes to Medicaid. An estimated 90 percent of the 22 Americans age 50 years or older will be affected by these changes. Given the greater use for health care of older than younger people, the loss of Medicaid coverage could have dire health consequences.

Question:

Can you describe how loss in health coverage due to work reporting requirements will increase costs in Medicare as seniors age into the program?

Due to the expiration of enhanced Premium Tax Credits (PTCs), older Americans are at risk of losing health care coverage due to facing one of the highest premium increases. This might have ripple effects on the rural healthcare system in states like Georgia, with 71 rural hospitals and 94 rural health clinics, which disproportionately serve older Americans.

Response:

Research suggests that people who were uninsured in the year before enrolling in Medicare had higher health needs and significantly higher costs than those who were previously uninsured.

Question:

How will the expiration of enhanced PTCs and Medicaid cuts affect the financial viability of rural hospitals and clinics in Georgia?

Response:

A recent analysis by the Urban Institute estimates that the failure to continue current premium tax credits will result in 7.3 million people losing ACA coverage and 4.8 million people becoming uninsured. This, in turn, would reduce office-based physician service spending by \$5.1 billion. It would also reduce hospital spending by \$14.2 billion and increase uncompensated care for hospitals by \$2.2 billion.

The analysis estimates that Georgia hospitals will be among the hardest hit, potentially experiencing a 20.8 percent increase in hospital uncompensated care. The National Rural Health Association estimates that 50 percent of rural hospitals nationwide are operating with negative margins: the funding reduction from the expiration of enhanced premium tax credits could cause them to reduce services or close altogether.

Question:

How can Congress alleviate the financial burden of rural health providers and the subsequent rise of healthcare costs among older Americans?

Response:

Congress could prevent rural health providers from seeing more uninsured, older Americans by extending the enhanced premium tax credits. Older Americans pay more than younger Americans for individual health insurance, so they will face higher out-of-pocket premiums. Additionally, over half of those who will lose eligibility for tax credits altogether are ages 50 to 64.

Further, Congress could limit the coverage loss from H.R. 1 in a number of ways, including exempting older Medicaid enrollees from its policies like work requirements.

In addition to doing no harm, Congress could take numerous actions to lower health care costs such as accelerating action on high drug prices, reducing overcharging by insurers and for-profit health care providers, and supporting safety net services and providers to maintain the health of rural and underserved communities.

Statements for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

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OCTOBER 22, 2025

STATEMENTS FOR THE RECORD

Alex Oshmyansky, MD, Ph.D. and Mark Cuban Statement

**Transparency is Better:
Evidence for Increased Drug Costs
Associated with Opaque Rebate-based
Drug Reimbursement Models**

Alex Oshmyansky, MD, PhD
Mark Cuban¹

¹ Mark Cuban Cost Plus Drug Company

Introduction

Here we outline the case that opaque rebate-based pharmaceutical reimbursement models used by pharmaceutical benefit managers lead to overall increased drug costs and therefore increased healthcare and premium costs. In particular, we focus on the inflationary effects of hidden net drug costs, other forms of information asymmetry in the pharmaceutical marketplace, vertically integrated pharmaceutical benefit managers, and tacit collusion in oligopolistic markets.

We organize our discussion in this document as follows:

Part I: Evidence of a Broken Market and Overall Loss of Market Efficiency

Section 1. Mark Cuban Cost Plus Drug Company Generic Pricing - Evidence of Significant PBM Market Inefficiencies

Given the opacity of the US industry around negotiating drug costs, information is extremely difficult to find on the effects of different drug pricing models on net drug costs. However, data from the Mark Cuban Cost Plus Drug Company shows that there are substantial price increases associated with a pricing model based on a discount from an inflated list price. This has been analyzed both internally and evaluated by multiple external academic and commercial organizations which finds MCCPDC generic pricing is not only substantially better than the big PBMs offer, but also better than available in most other nations with a central state negotiating authority. We argue there is no reason to believe that the brand pharmaceutical market should behave differently than the generic market given that the same parties are negotiating on behalf of the same clients. There is also often significant competition within a therapeutic category for on patent medications (several GLP-1s, JAX2 inhibitors, etc.).

Section 2. Evidence for Extreme Information Asymmetry in the PBM Market

Here we argue that one of the root causes of market inefficiencies in the pharmacy benefit management space are extreme information asymmetry between buyers and sellers. Evidence

for extreme information asymmetry includes that claims data is unavailable to both buyers and sellers in the market, the persistent appearance of spread pricing and DIR fees in pharmacy reimbursement, the presence of offshore rebate aggregation GPOs with hidden fees, and the overall presence of a "gross-to-net bubble" where true drug costs are hidden.

Section 3. Evidence for Tacit Collusion Between Large PBMs.

We discuss evidence for tacit collusion between the major PBMs. For example, within the rebate aggregator GPO market for small PBMs attempting to get access to rebates. Zinc and Emisar also do not open themselves up for contracting. There is thus effectively a monopoly market with Ascent as the only vendor.

Part II: MCCPDC Position compared to Specific CBO Positions (Email dated July 25th, 2025)

Section 4. Effects of Vertical Integration of Payers and PBMs

The largest 3 PBMs are vertically integrated with large insurers. However, the PBM component of these organizations is larger in terms of revenue and earning than the insurer. As such, these organizations are:

- i) Incentivized to maximize sources of revenue (fees, spread pricing, etc.) from their PBM division;
- ii) Insulated from such fees as they amount to an intra-company transfer for their own insurance divisions;
- iii) Actually incentivized to keep drug costs and PBM costs higher to ensure compliance with medical loss ratio (MLR) requirements.

Section 5: PBM Contracting is Compulsory not Strategic

Plan sponsors contract with PBMs because it is compulsory to get access to pharmaceutical benefits, not because they believe it offers the best deal. There is currently no path to independently negotiate a comprehensive pharmaceutical benefit.

Section 6: PBM Margins are Significantly Higher When Calculated Based on Net Drug Costs

PBMs generally publicly report relatively narrow operating margins. However, we demonstrate

that these margins are actually significantly higher when calculated as a percentage of net rather than gross drug costs. We also show that margins can be hidden within a wide variety of subsidiary entities.

Section 7. Statistical Dynamics of Rebate Distributions

The CBO assumes that there is a rightward positive skew towards the distribution of pharmaceutical rebates as there is a minimum rebate amount of 0%. An opaque market should increase the standard deviation of the distribution and therefore increase the positive skew and the overall rebate amount. However, we argue there is no empirical evidence of what the distribution of pharmaceutical rebates looks like. All such information is confidential, so actual rebate amounts on all drugs are hidden. However:

- i) rebates are also capped at an upper limit of 100%;
- ii) we can again look at the generic market for a representative data set. Here mean discounts tend to fall at 79-89%, which implies there is actually a leftward, negative skew in the underlying probability distribution;
- iii) Fees charged as a percentage of list prices effectively increase the leftward skew of this distribution, resulting in increased costs.

Section 8. Effects of Vertical Integration of PBMs with Pharmaceutical Manufacturers, Pharmacies, and other Supply Chain Vendors

Again, we argue participating in vertically integrated supply chains is compulsory rather than a proactive choice by plan sponsors. Cost Plus Drugs data shows that in house, captive specialty pharmacies create a substantial markup on the cost of generic specialty medications. Our data also shows that PBM owned virtual manufacturers also create a significant markup on generic and biosimilar products. We argue, there is no reason to believe a similar markup does not occur on single-source branded products. Overall, PBMs are intended to act as negotiating entities between plan sponsors and pharmaceutical manufacturers and pharmacies. It is an inherent conflict of interest for PBMs to own their own pharmaceutical manufacturers and pharmacies.

Section 9. Effects of List Prices on Patient Co-insurance

Increasing list prices may save plan sponsors money in the short term by increasing member coinsurance, but there is significant evidence that increasing co-insurance drives medication

noncompliance and increases medical benefit spend that is greater than pharmaceutical savings. The CBO's own analysis shows a net increase in Medicare plan spending for each point of increased member co-payment obligation.

Section 10. Maximizing Harm: An Analysis of How PBM-Run Co-Payment Maximizer Programs Inflate Healthcare Costs and Burden Patients

Here we discuss co-payment maximizer programs run by PBMs and how they are used to inflate drug costs. We discuss how co-payment maximizers are used to recategorize rebate dollars into administrative fees, thus foiling supposed rebate-pass through contractual relationships. We discuss how co-payment maximizers further shift market volume to lucrative PBM owned specialty pharmacies.

Part III: Effects of the Pharmaceutical Wholesaler Oligopoly

Section 11. The Wholesaler Oligopoly: An Analysis of Market Control, Price Inflation, and Supply Chain Fragility in U.S. Pharmaceutical Distribution

The big 3 pharmaceutical wholesalers work in concert with the big 3 pharmaceutical manufacturers to ensure a distribution system where there is limited to no competition and extreme information asymmetry. The dynamics here not only drive up drug costs, but create a brittle supply chain prone to drug shortages. Here we dive more deeply into specific problematic practices including:

- i) Generic Compliancy Ratios
- ii) Pharmacy Services Administrative Organizations
- iii) Generic Sourcing Alliances
- iv) Failure to supply clauses and other coercive contracting practices
- v) Financial engineering and "float"
- vi) Pharmacy Switches

Section 12: PBMs and Wholesalers: Colluding for Control

Here we discuss how PBMs and wholesalers reinforce each other's oligopolies. We discuss how the deep business ties between PBMs and wholesalers incentivize both to mutually support a distribution system based on artificially inflated list prices and hidden net costs. In particular, we discuss:

- i) The nature of PBM-Wholesaler joint ventures and other financial relationships
- ii) The conflicts of interests faced by wholesaler owned PSAOs and how they paradoxically benefit from retail pharmacy closures.
- iii) How the PBM-Wholesaler relationship ensures transparent price models cannot reach the market due to the threat of "double rebating" to manufacturers

Part IV: Hospitals and Pharmaceutical Prices

Section 13. The 340B Profit Paradox: How Pharmacy Benefit Managers Reshaped a Public Health Program into a Financial Windfall

We discuss how the 340B program, though initially well intentioned as a program to reduce drug costs and act effectively as a subsidy to hospitals that provide care to underserved communities, has now also become a profit center for PBMs and other market intermediaries. We discuss the rise of contract pharmacies and how poorly monitored "virtual inventory" systems have created a slush fund for PBMs.

Section 14. Price Distortions in the Medical Benefit: An Analysis of Perverse Incentives and Vertical Integration in the U.S. Pharmaceutical Supply Chain

Drugs procured through hospitals are marked up by financial intermediaries in a manner similar to pharmaceuticals procured through pharmacies. Here, we discuss the specifics including commercial insurance markups on pharmaceuticals, the incentives to switch products between the medical and pharmacy benefit to captive PBM specialty pharmacies, ASP pricing dynamics, and the rise of wholesaler owned physician practices.

Section 1. Mark Cuban Cost Plus Drug Company Generic Pricing - Evidence of Significant PBM Market Inefficiencies

Mark Cuban Cost Plus Drug Company launched in January of 2022 with a business model centered around reducing the costs of generic drugs, particularly so-called “ultra-high-cost” generic drugs or “specialty generic” drugs. Operating on a transparent cost-plus pricing model—defined as the manufacturer’s cost plus a 15% margin, a \$3 pharmacy fee, and a \$5 shipping fee—the company aims to counteract the price opacity and inefficiencies endemic to the traditional drug supply chain.¹ By contrast, most major PBMs contract for generic drugs on a so called “AWP minus” contracting model. In this model, a standard confidential discount amount ranging from 79-89%, is applied to the cost of generic drug products. Often, PBMs are able to keep a percentage of “spread” between the negotiated discount with a payer and actual amount reimbursed to a pharmacy if the amount differs.

The analysis here reveals a substantial potential for system-level savings, primarily benchmarked against the Medicare Part D program, with the Mark Cuban Cost Plus Pricing model. Academic studies project that Medicare could save billions of dollars annually by adopting MCCPDC’s pricing for even a limited subset of generic drugs. Initial research indicated potential savings of up to \$3.3 billion per year on 77 generics, while more recent, expansive studies estimate this figure could be as high as \$8.6 billion as MCCPDC’s formulary grows.² These savings are most pronounced for high-cost generics in specialty areas like oncology and cardiology.

Academic Data

The majority of academic research evaluating the financial impact of MCCPDC has focused on its potential to reduce costs for large-scale payers. The Medicare Part D program, due to its publicly available and comprehensive spending data, has served as the primary benchmark for these economic evaluations. The findings consistently point to a multi-billion-dollar savings opportunity, highlighting systemic overpayment for generic drugs within the current reimbursement framework.

Broad-based studies examining a wide range of generic medications have established the significant scale of potential savings for the Medicare program. A foundational cross-sectional study published in the *Annals of Internal Medicine* analyzed 89 generic drugs available from MCPPDC in early 2022 against 2020 Medicare Part D spending data.² The research concluded that if Medicare had purchased these drugs at MCPPDC prices, it could have saved up to **\$3.3 billion annually**, representing a 36% cost reduction on 77 of the 89 drugs analyzed.² This estimate was based on purchasing the maximum quantity supplied by MCPPDC (e.g., 90-day fills), a variable that proved critical to maximizing savings.

A more recent and expansive retrospective study, published in 2024, leveraged 2021 Medicare Part D data against MCPPDC's expanded formulary as of August 2023.⁴ This analysis identified even greater potential savings, estimating that Medicare Part D could have saved a total of **\$8.6 billion** by utilizing 90-day MCPPDC pricing.⁴ The study found that nearly 80% of the examined drugs were more cost-effective through MCPPDC's platform.⁴ This larger figure demonstrates that as MCPPDC has increased the number of medications it offers, its potential to generate systemic savings has grown commensurately.

These analyses consistently conclude that the Medicare program is systemically overpaying for many generic drugs. To understand where these savings are most concentrated, several studies have conducted granular analyses of specific, high-expenditure therapeutic areas. These evaluations reveal that the potential for savings varies significantly across clinical domains, often correlating with the baseline cost and market dynamics of the drugs in question.

- **Oncology:** Research led by Vanderbilt University and published in the *Journal of Clinical Oncology* focused on seven generic oral oncology drugs. The study found that Medicare could save between **\$228 million and \$2.15 billion annually**, with the range depending on whether MCPPDC prices were compared to the 25th or 75th percentile of Part D plan prices.¹ The analysis highlighted dramatic price disparities for individual drugs. For instance, a 30-day supply of abiraterone (brand name Zytiga) cost \$44.60 from MCPPDC, compared to a median cash-pay price of \$562.49.¹ For patients, the potential annual savings for high-cost generics like abiraterone and imatinib (brand name Gleevec) could exceed \$20,000.¹¹ This demonstrates that MCPPDC's model is a powerful corrective mechanism in the high-cost generic market, where prices often remain artificially inflated despite the loss of patent exclusivity.

- **Cardiology:** A study of the 50 most-used generic cardiology drugs, which represented a \$7.7 billion market for Medicare Part D in 2020, found substantial savings potential.¹³ A conservative estimate using 30-day supplies yielded savings of **\$1.3 billion (17%)** on 16 of the 50 drugs. A less conservative estimate based on 90-day supplies projected savings of **\$2.9 billion (38%)** across 35 of the 50 drugs.¹³
- **Urology and Men's Health:** An analysis of the nine most popular oral urological drugs concluded that Medicare could have saved approximately **\$1.29 billion** based on 2020 expenditures.¹ A distinct study focusing on 15 men's health medications found potential annual savings of **\$1.1 billion** for 30-count prescriptions and **\$1.3 billion** for 90-count prescriptions.¹⁶
- **Neurology:** A study of 15 anti-seizure medications found that while 30-count prescriptions offered savings of **\$172 million** on 60% of the drugs, this was partially offset by higher costs on others. However, when shifting to 90-count prescriptions, the savings grew to **\$373 million** across 80% of the drugs, a 31.6% reduction from Medicare prices.¹⁸
- **Otolaryngology:** An analysis of common medications in this specialty estimated potential savings of **\$55.6 million**, with a projection that savings could reach **\$1 billion** if a similar rate were applied across all medical specialties.¹⁹

The following table synthesizes the findings from these specialty-specific studies, providing a comparative overview of the potential annual savings for the Medicare program.

Table 1: Summary of Potential Annual Medicare Savings by Medical Specialty

Medical Specialty	Drugs Analyzed in Study	Estimated Annual Savings (USD)	Key Findings/Context	Source(s)
Oncology	7 generic oral drugs	\$228 million – \$2.15 billion	Range reflects comparison to 25th-75th percentile Part D prices.	
Cardiology	50 most-used generic drugs	\$1.3 billion – \$2.9 billion	Lower estimate for ¹³ 30-day supply; higher for 90-day	

			supply.	
Urology	9 popular oral drugs	~\$1.29 billion	Based on 2020 Medicare expenditures.	
Men's Health	15 men's health drugs	\$1.1 billion - \$1.3 billion	Lower estimate for ⁶ 30-day supply; higher for 90-day supply.	
Neurology	15 anti-seizure drugs	\$172 million - \$373 million	Lower estimate for ⁸ 30-day supply; higher for 90-day supply.	
Otolaryngology	Common specialty drugs	~\$55.6 million	Projected to \$1 billion if savings rate applied across all specialties. ⁹	

MCCPDC's simple, transparent cost-plus formula serves as a powerful "market truth-teller," standing in stark contrast to the opaque and convoluted pricing mechanisms of the traditional pharmaceutical supply chain.³ The conventional system is dominated by PBMs, intermediaries that negotiate confidential rebates with drug manufacturers in exchange for preferential placement on insurance formularies.²⁴ This process obscures the true net price of a drug and creates incentives that can lead to higher list prices, which disproportionately harms uninsured individuals and those with high-deductible health plans.²⁴

By circumventing PBMs and negotiating directly with manufacturers, MCCPDC demonstrates the prices that are achievable when these intermediary costs and misaligned incentives are removed.²⁴ In effect, the numerous academic studies comparing MCCPDC prices to Medicare prices are quantifying the immense cost of this systemic inefficiency.² The public disclosure of this value gap has elevated the national conversation around drug pricing, drawing attention from policymakers and regulators to the flow of money within the supply chain.²⁸

Internal Cost Plus Drugs Data and Commercial Consultancy Evaluations

In addition to the publicly available literature on specific therapeutic categories, Mark Cuban Cost Plus Drug Company has performed commercial evaluations of its transparent price model for multiple plan sponsors based on their data sets. These evaluations are available upon request, but are commercially sensitive for MCPPDC clients, so not shared directly here. However, they show comparable savings to those shown in the academic literature of approximately 50-60% savings on overall generic drug spend.

Independent commercial consultancy evaluation Mark Cuban Cost Plus Drug Company data against Medicare data have also shown similar results: <https://www.46brooklyn.com/research/072224-how-mark-cuban-reveals-hidden-costs-of-variable-drug-prices-in-medicare> .

Section 2. Evidence for Extreme Information Asymmetry in the PBM Market

PBMs originated in the 1960s as relatively simple third-party administrators, primarily tasked with processing prescription drug claims for insurance plans.³ Over the subsequent decades, their role has expanded dramatically. Today, PBMs are powerful, complex entities that manage nearly every facet of the prescription drug benefit, from creating drug formularies and negotiating manufacturer rebates to establishing pharmacy networks and conducting utilization reviews.³ This evolution has been accompanied by massive market consolidation. The "Big Three" PBMs—CVS Caremark, Express Scripts (owned by Cigna), and OptumRx (owned by UnitedHealth Group)—now control approximately 80% of the market, effectively creating an oligopoly.³

This market concentration is compounded by extensive vertical integration. Each of the Big Three PBMs is co-owned with a major health insurer and operates its own mail-order and specialty pharmacies.⁴ This structure creates profound and often unmanaged conflicts of interest, deepening the information gap between the PBM and its clients. A plan sponsor may contract with the "PBM" arm of a conglomerate while having no visibility into the profits being generated from its own members by the "specialty pharmacy" arm or the "offshore rebate aggregator" arm of the same parent company. This intricate corporate structure is not an accidental byproduct of market evolution; it is a deliberately constructed architecture of opacity. The complexity is a feature, not a bug, designed to create and exploit information asymmetry at multiple, invisible revenue extraction points.

This report argues that the extreme information asymmetry created and exploited by PBMs—through mechanisms such as spread pricing, secret post-sale fees, offshore rebate aggregation, and contractual data restrictions—systematically inflates prescription drug costs, harms patients and pharmacies, and undermines the fiduciary responsibilities of plan sponsors.

The "Spread" – Profiting from the Gap Between Payment and Reimbursement

One of the most direct and egregious mechanisms through which PBMs leverage information asymmetry is "spread pricing." This practice is defined as the difference between the amount a PBM charges a health plan sponsor for a prescription drug and the amount it reimburses the dispensing pharmacy for that same drug.⁹ The PBM pockets this difference, or "spread," as undisclosed profit. This revenue stream is distinct from any administrative fee the PBM charges and is often hidden within complex contracts that prevent the plan sponsor from seeing both sides of the transaction.¹¹

While the existence of spread pricing has long been suspected, a series of state-level audits and independent analyses have provided powerful quantitative evidence, piercing the veil of PBM pricing and revealing the scale of this practice, particularly in state Medicaid programs.

- **Ohio:** A 2018 report from the Ohio Auditor of State found that PBMs collected a total of \$224.8 million in spread from the state's Medicaid managed care program in a single year. Critically, the analysis revealed a strategic targeting of the generic drug market. While the spread on brand-name drugs was a mere 0.8% of their cost, the spread on generic drugs was a staggering 31.4%, accounting for \$208.4 million of the total. This means that for every dollar Ohio's Medicaid program spent on generics, nearly 32 cents was retained by the PBM as hidden profit.¹³
- **Kentucky:** A state-commissioned report revealed that PBMs took in \$123.5 million annually from the Medicaid program through spread pricing. This discovery prompted an investigation by the state's Attorney General into allegations of overcharging and discrimination against independent pharmacies.¹⁴
- **Massachusetts:** An analysis by the state's Health Policy Commission (HPC) found that PBM prices for generic drugs were "markedly higher" than the actual pharmacy acquisition cost. In one striking example, the price charged for the generic cancer drug Gleevec was, on average, \$1,811 more per prescription than what pharmacies paid to acquire it.¹⁷
- **Arkansas:** Arkansas has been a national leader in PBM reform, enacting legislation that explicitly prohibits spread pricing after its detrimental effects on the state's Medicaid program and pharmacies were identified.¹⁰

These state-level findings are corroborated by independent research. A 2024 analysis

of commercial plan data in Washington State by 3Axis Advisors found that for a subset of matched claims, employer costs were approximately 80% higher than what pharmacies were reimbursed. This translated to an average spread of over \$8 per prescription. The analysis further revealed that between 2020 and 2023, while employer costs for drugs rose by 30%, pharmacy reimbursement for those same drugs *decreased* by 3%, indicating that the spread is not static but is actively widening over time.²⁰

State/Study	Time Period	Program	Total Spread Identified (\$)	Spread as % of Generic Drug Cost	Key Drug Example
Ohio Auditor of State ¹³	2017-2018	Medicaid	\$224.8 Million	31.4%	Not Specified
Kentucky Cabinet for Health ¹⁵	2018	Medicaid	\$123.5 Million	Not Specified	Not Specified
Massachusetts HPC ¹⁷	2018	Medicaid & Commercial	Not Specified	Not Specified	Generic Gleevec price was \$1,811 above acquisition cost
3Axis Advisors (Washington) ²⁰	2020-2023	Commercial	80% higher employer cost than pharmacy reimbursement	Not Specified	Buprenorphine-naloxone charged to plan at \$100.12 above cost

The consistent pattern revealed by these audits demonstrates a fundamental misalignment of incentives. Plan sponsors are universally encouraged by their PBMs to promote generic drug dispensing as the primary strategy for controlling pharmacy costs. Yet, the data conclusively show that these same low-cost generic drugs have been converted into the PBMs' most lucrative and opaque profit center. Every time a plan sponsor believes it is "saving" money by steering a member to a generic alternative, it may in fact be maximizing the PBM's hidden profit. This creates a perverse incentive for PBMs to manipulate the Maximum Allowable Cost (MAC) lists—the reimbursement benchmarks for generic drugs—not to secure the lowest possible net cost for their clients, but to create the largest possible spread for themselves. The PBM profits directly from the opacity of the generic drug market, not from its

efficiency.

The Shadow Financial System: Post-Sale Fees and Rebate Obfuscation

Beyond the direct markup of spread pricing, PBMs have developed a sophisticated shadow financial system that operates after the point of sale, further obscuring the true cost of medications. This system relies on two primary pillars: retroactive "clawback" fees charged to pharmacies and an opaque rebate structure negotiated with drug manufacturers.

The Mechanics of DIR Fees

Direct and Indirect Remuneration (DIR) is a term created by the Centers for Medicare & Medicaid Services (CMS) to account for all post-sale price concessions, primarily manufacturer rebates, that affect the final cost of drugs in the Medicare Part D program.²³ However, PBMs have co-opted this term to justify a wide array of retroactive fees they charge to pharmacies, often weeks or months after a prescription has been dispensed and the initial claim paid.²⁵ These fees are frequently disguised as "performance-based" adjustments, network participation fees, or administrative charges, but their application is often arbitrary and lacks transparency.²³

The financial impact of these fees has been explosive. According to CMS data, pharmacy DIR fees grew by a staggering 107,400% between 2010 and 2020.²⁸ This practice has devastating consequences for both pharmacies and patients:

- **Impact on Pharmacies:** The retroactive nature of DIR fees creates profound financial uncertainty. A pharmacy may dispense a medication believing it has made a small profit, only to have that profit (and more) clawed back by the PBM months later. This makes it impossible for pharmacies to know their true reimbursement at the point of sale, threatening their financial viability and disproportionately harming independent pharmacies that lack the scale to absorb such unpredictable losses.²⁹
- **Impact on Patients and Payers:** Because DIR fees are assessed post-transaction, they are not reflected in the drug's price at the pharmacy counter. Patient cost-sharing (copayments and coinsurance) is calculated based on this inflated pre-rebate, pre-DIR price. This directly increases patients' out-of-pocket costs and causes them to advance

more quickly through the phases of the Part D benefit.²⁴

The Rebate System and the "Gross-to-Net Bubble"

The second pillar of this shadow system is the complex and secretive world of manufacturer rebates. PBMs leverage their control over millions of patient lives to negotiate substantial rebates from pharmaceutical manufacturers in exchange for giving a drug preferential placement on their formularies.³³ While PBMs claim these rebates lower drug costs, the evidence points to a perverse incentive structure that actually fuels price inflation. Economic analysis reveals a direct and powerful correlation: on average, a \$1 increase in negotiated rebates is associated with a \$1.17 increase in a drug's list price.³⁵ This occurs because PBM administrative fees are often calculated as a percentage of the list price, and higher rebates are used to secure more favorable formulary status. This creates a feedback loop where manufacturers are incentivized to set a high list price to be able to offer a large rebate, which in turn benefits the PBM. The widening chasm between the publicly stated list price and the actual post-rebate net price is known as the "gross-to-net bubble."

A recent Federal Trade Commission (FTC) lawsuit against the Big Three PBMs regarding insulin pricing provides a stark case study. The FTC alleges that the PBMs created a "perverse drug rebate system" that systematically favored high-list-price, high-rebate insulin products while actively excluding new, lower-list-price alternatives from their formularies. This practice, the FTC argues, directly harmed patients who pay cost-sharing based on the inflated list price, all while maximizing PBM profits.³⁶

Revenue Stream	Definition	Mechanism	Primary Payer	Primary Beneficiary	Consequence
Spread Pricing ³⁷	Difference between what a PBM charges a plan and what it pays the pharmacy.	PBM charges plan \$50 for a drug but reimburses pharmacy only \$10.	Health Plan Sponsor	PBM	Inflates plan sponsor costs; lacks transparency.
DIR Fees ²³	Post-point-of-sale fees clawed back from	PBM retroactively deducts fees based on	Pharmacy	PBM	Creates financial instability for pharmacies;

	pharmacies.	arbitrary "performance" metrics.			inflates patient cost-sharing.
Rebate Retention ³⁸	PBM keeps a portion of manufacturer rebates instead of passing them to the plan.	PBM contract defines "rebates" narrowly, excluding other manufacturer payments.	Manufacturer (funded by high list prices)	PBM	inflates list prices; reduces savings for plan sponsor.
Administrative Fees ³⁹	Fees charged for managing the drug benefit, often tied to the drug's list price.	PBM charges a % of the Wholesale Acquisition Cost (WAC) as an admin fee.	Health Plan Sponsor	PBM	Incentivizes PBM to favor high-list-price drugs.
Clawbacks ³⁷	PBM collects more from a patient's copay than the drug's cost and claws back the excess from the pharmacy.	Patient copay is \$15, but drug cost to plan is \$5. PBM takes the \$10 difference from the pharmacy.	Patient / Pharmacy	PBM	Increases patient out-of-pocket costs.
Data Sales Fees ⁴⁰	PBM sells aggregated, de-identified patient claims data to third parties.	PBM monetizes the plan sponsor's data without sharing revenue.	Health Plan Sponsor (indirectly)	PBM	Raises privacy and conflict-of-interest concerns.

The entire system of post-sale remuneration—encompassing both DIR fees from pharmacies and rebates from manufacturers—is engineered to create a fundamental disconnect between the price a patient sees at the counter and the final net cost of the drug. A rational, transparent market would strive to make these two figures as close as possible. Instead, the PBM model thrives by making the point-of-sale price an intentionally poor signal of the actual underlying cost. This manufactured disconnect is an engine of information asymmetry, enabling a massive transfer of wealth from patients (through inflated cost-sharing) and pharmacies (through clawbacks) to PBMs and their affiliated insurers.

The Black Box: Data Secrecy, Contractual Restrictions, and the Erosion of Fiduciary Duty

The financial mechanisms detailed above are sustained by a fortress of contractual and legal barriers that prevent plan sponsors from accessing the information needed for effective oversight. PBMs operate as a "black box," controlling the flow of data to maintain their informational advantage and protect their opaque revenue streams.

PBM contracts are notoriously complex and frequently contain clauses that severely limit a plan sponsor's ability to access and audit their own complete, unadulterated pharmacy claims data.⁴¹ PBMs often define what constitutes auditable data in the narrowest possible terms, provide aggregated summary reports instead of granular, claim-level data, and assert that critical financial information—such as the true amounts paid to pharmacies or the full value of rebates received from manufacturers—is proprietary or a "trade secret".⁴⁰ This practice effectively prevents the client from verifying whether they are receiving the benefit of their bargain.

This contractual secrecy creates a profound dilemma for most employers and plan sponsors, who are governed by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA imposes a strict fiduciary duty on plan sponsors, legally obligating them to act prudently and solely in the interest of plan participants and their beneficiaries. A key component of this duty is ensuring that all plan expenses, including payments to vendors like PBMs, are reasonable and necessary.⁴³ The conflict is self-evident: how can a plan sponsor fulfill its legal duty to ensure costs are reasonable without access to the very data needed to validate those costs?

This untenable situation has led to a recent wave of class-action lawsuits. Significantly, these lawsuits are not targeting PBMs directly, but rather the plan sponsors themselves for breaching their ERISA fiduciary duties. Cases like *Lewandowski v. Johnson & Johnson* allege that the employer failed in its duty of prudence by not adequately managing its PBM contract, allowing the plan to pay excessively for prescription drugs.⁴⁵ This litigation trend underscores the immense legal risk that PBM-enforced opacity creates for their own clients.

The PBM playbook of controlling information flow has also historically extended to the consumer level through the use of "gag clauses." These were contractual provisions that explicitly prohibited pharmacists from informing patients that the cash price for a drug might

be lower than their insurance copayment.⁴⁹ This practice represents a direct enforcement of information asymmetry at the point of care. While these clauses have now been largely banned by federal and state laws, their widespread use demonstrates a core PBM strategy: to manage and restrict the flow of financial information at every level of the supply chain to protect their revenue.⁵¹

In response to these issues, lawmakers have begun to act. The federal Consolidated Appropriations Act (CAA) of 2021 included provisions to ban gag clauses and enhance transparency requirements.⁵¹ Concurrently, several states have moved to impose a direct fiduciary duty on PBMs, seeking to legally compel them to act in their clients' best interests.⁵⁴ Ultimately, PBMs have leveraged their role as data custodians to create a classic "principal-agent" problem. The agent (the PBM) possesses far more information than the principal (the plan sponsor), allowing the agent to act in its own self-interest rather than the principal's. The legal framework of ERISA, however, was designed for a world where the plan sponsor had visibility and control over plan expenses. By inserting themselves as opaque intermediaries, PBMs have shifted this dynamic, placing the legal liability for their own self-dealing practices squarely on the shoulders of their clients. The recent surge in litigation against plan sponsors is the logical outcome, representing an attempt by plan participants to force the principal to reclaim control from its conflicted agent. The information asymmetry has created a massive, unmanaged legal risk for virtually every self-funded employer in the country.

The Offshore Veil: How Foreign GPOs Amplify Opacity and Costs

In recent years, the largest PBMs have added a new and even more opaque layer to their corporate structures: offshore Group Purchasing Organizations (GPOs). These entities, established in foreign, low-tax jurisdictions, represent the ultimate expression of information asymmetry, designed to place the most critical financial data legally and geographically outside the reach of U.S. clients and regulators.

The "Big Three" PBMs have each established such an entity:

- **Ascent Health Services:** Owned by Cigna (parent of Express Scripts) and located in Switzerland.⁵⁶
- **Emisar Pharma Services:** Owned by UnitedHealth Group (parent of OptumRx) and located in Ireland.⁵⁷

- **Zinc Health Services:** Owned by CVS Health (parent of CVS Caremark) and based in the U.S., but operates in a similarly opaque manner as a rebate aggregator.⁵⁶

These organizations are not traditional GPOs that purchase goods and services. Instead, they function as "rebate aggregators," centralizing the high-stakes rebate negotiations with pharmaceutical manufacturers on behalf of their PBM owners and other PBM partners.⁵⁹ This structure creates a crucial layer of legal separation. The PBM can then claim to its clients that the sensitive rebate contracts are held not by the PBM itself, but by this separate GPO entity, making them inaccessible for audits.⁵⁶

Investigations by the U.S. House Oversight Committee, the Senate Finance Committee, and the FTC have concluded that a primary purpose of this offshore structure is to shield rebate and fee arrangements from burgeoning U.S. transparency laws, regulatory oversight, and client audits.³³ A lawsuit filed by the Ohio Attorney General explicitly alleges that Express Scripts formed Ascent in Switzerland to "illegally drive up drug prices" and conceal its rebate schemes.⁶¹

These offshore GPOs are central to the price inflation mechanism. The FTC alleges that these are the entities that demand the massive rebates from manufacturers, which in turn forces manufacturers to set higher list prices to fund those rebates.³⁶ This system transforms the information asymmetry from a domestic contractual issue into a complex international corporate law problem, making it exponentially more difficult for a plan sponsor to penetrate. It is a form of regulatory and legal arbitrage. As state and federal reforms in the U.S. increase pressure for transparency, this offshore structure provides a potential shield. A PBM facing a U.S. law requiring full rebate disclosure could argue that it is complying by passing through 100% of the rebates *it* receives, while conveniently ignoring the vast sums retained by its own offshore affiliate before any funds are ever transferred to the U.S.-based PBM entity.⁵⁹ It is a legal fiction designed to circumvent fiduciary and contractual obligations.

Section 3. Evidence for Tacit Collusion Between Large PBMs

Here we present a comprehensive analysis of the U.S. Pharmacy Benefit Manager (PBM) market, arguing that the market structure, dominated by the "Big Three" PBMs—CVS Caremark, Express Scripts, and OptumRx—facilitates a state of tacit collusion. This anticompetitive coordination is not achieved through explicit agreements but through a sophisticated alignment of business practices and market structure that serves the collective interests of the dominant firms at the expense of patients, payers, and the broader healthcare system.

One of the central mechanisms for this collusion is identified as the PBM-affiliated Group Purchasing Organizations (GPOs)—Ascent Health Services, Zinc Health Services, and Emisar Pharma Services. These entities, often domiciled offshore in jurisdictions known for financial opacity like Switzerland and Ireland, centralize and obscure the negotiation of manufacturer rebates. These rebates are the primary driver of drug formulary placement and, consequently, drug prices. By creating a complex and non-transparent layer between manufacturers and the PBMs, these GPOs make it nearly impossible for plan sponsors to fulfill their fiduciary duties and for regulators to conduct effective oversight.

We demonstrate that while Zinc and Emisar operate as captive GPOs for their parent companies (CVS and OptumRx, respectively), Ascent Health Services (affiliated with Express Scripts/Cigna) functions as a unique, market-wide utility. Ascent is the only major GPO that provides rebate aggregation services to a host of smaller PBMs, including direct competitors of its parent company. This arrangement is not a sign of a competitive market but rather dispositive evidence of a sophisticated, unspoken market-sharing agreement. By controlling the sole gateway for smaller PBMs to access essential manufacturer rebates, the Big Three effectively neutralize competitive threats, coordinate on rebate levels, and maintain a system of inflated list prices that benefits them collectively. This structure constitutes a monopoly on rebate access for smaller market participants, a monopoly that is tacitly sanctioned by the other two dominant players who refrain from competing in this specific service area.

The consequences of this collusive structure are severe and systemic. It perpetuates the "gross-to-net bubble," where soaring list prices directly harm patients with deductibles and coinsurance, even as net prices paid by PBMs stagnate. It contributes to the financial

strangulation of independent pharmacies through below-cost reimbursements and retroactive fees, leading to the proliferation of “pharmacy deserts” in vulnerable communities. It creates a profound information asymmetry that undermines market efficiency and prevents plan sponsors from meeting their fiduciary responsibilities under the Employee Retirement Income Security Act (ERISA).

The Architecture of an Oligopoly: Market Concentration

The U.S. prescription drug market is not a free market in any traditional sense. It is an oligopoly, a market structure characterized by a small number of dominant firms whose strategic decisions are interdependent. The structural conditions of the Pharmacy Benefit Manager (PBM) sector—extreme market concentration and deep vertical integration—create an environment where anticompetitive coordination is not only possible but is the rational outcome of market dynamics. Understanding this architecture is the first step in identifying the mechanisms of tacit collusion that define the industry.

Dominant Market Share

The PBM market is a classic oligopoly, defined by the overwhelming dominance of three entities. The “Big Three”—CVS Caremark (a subsidiary of CVS Health), Express Scripts (a subsidiary of Cigna), and OptumRx (a subsidiary of UnitedHealth Group)—collectively process approximately 80% of all prescription claims in the United States.¹ This concentration means that the pharmacy benefits of nearly 270 million Americans are managed by just three firms, which collectively handled a market of almost \$600 billion in 2024.¹

This level of market concentration is a critical precondition for tacit collusion. Economic theory posits that collusion, whether explicit or tacit, is easier to achieve and sustain when the number of firms is small.⁴ With only three major players, each firm can more easily monitor the actions of its rivals, predict their responses, and recognize their mutual interest in avoiding aggressive price competition. The Herfindahl-Hirschman Index (HHI), a measure of market concentration used by antitrust regulators, far exceeds the threshold for a “highly concentrated” market in the PBM sector, signaling a significant lack of competition.⁶ This structural reality simplifies the coordination necessary for oligopolistic firms to maintain supracompetitive pricing and profit levels.

The Web of Vertical Integration

The market power of the Big Three is magnified by their deep vertical integration across the healthcare supply chain. These PBMs are not standalone companies; they are core components of some of the largest and most powerful healthcare conglomerates in the world. Each PBM is integrated with a major health insurer: CVS Caremark with Aetna, Express Scripts with Cigna, and OptumRx with UnitedHealthcare.⁸

This integration extends downstream as well. Each of the Big Three owns its own specialty, mail-order, and, in the case of CVS, large-scale retail pharmacies.⁹ This vertical structure grants them unparalleled control over the entire pharmaceutical value chain. They influence which drugs are covered (formulary design), how much is paid for them (rebate negotiation), where patients can get them (pharmacy networks), and who pays for them (insurance benefit design). This end-to-end control creates a closed loop where the PBM can direct billions of dollars in pharmaceutical spending to its own affiliated businesses, often without the full knowledge of the plan sponsors who are ultimately paying the bills.

Anticompetitive Consequences of Vertical Integration

The vertical integration of the PBM-insurer-pharmacy conglomerate is not merely a strategy for achieving efficiencies; it is a powerful tool for enforcing market discipline and executing anticompetitive strategies. This structure creates profound conflicts of interest that harm patients, independent pharmacies, and the competitive landscape.

One of the most well-documented anticompetitive practices enabled by vertical integration is "patient steering." The House Oversight Committee and the Federal Trade Commission (FTC) have found extensive evidence that PBMs use their control over pharmacy networks and benefit design to steer patients, particularly those on high-cost specialty medications, to their own affiliated mail-order and specialty pharmacies.¹¹ This is often accomplished by making it financially punitive for a patient to use an independent pharmacy, either by imposing higher out-of-pocket costs or by designating the PBM's own pharmacy as the exclusive option for certain drugs.¹⁴ Plan sponsors are also penalized if chargebacks if they purchase outside of the assigned pharmacy or pharmacy network.

This practice serves two purposes. First, it captures highly profitable specialty drug revenue for the PBM's parent company. An FTC interim report found that PBM-affiliated

pharmacies now account for nearly 70% of all specialty drug revenue.¹⁶ Second, it systematically disadvantages and undermines independent and competing pharmacies by siphoning off their most valuable patients. This financial pressure is a key factor in the alarming rate of independent pharmacy closures, which has disproportionately affected rural and underserved urban communities, leading to the creation of “pharmacy deserts” where patients lack convenient access to essential pharmacy services.¹⁷

The vertically integrated structure of the Big Three is not simply a business model; it is a mechanism for control. It allows these firms to enforce the unwritten rules of the oligopoly. Any market participant—be it a drug manufacturer, a competing pharmacy, or even a health plan sponsor—that attempts to deviate from the established high-rebate, high-list-price paradigm can be swiftly punished. For example, a drug manufacturer that wishes to introduce a new, innovative drug with a low list price and a minimal rebate poses a threat to the PBMs’ profitable model, which thrives on large rebates calculated from high list prices. A pharmacy willing to sell with a lower gross margin is also a potential competitive threat. The integrated PBM-insurer can retaliate by simply refusing to place this disruptive drug on its formulary, effectively denying it access to the millions of patients covered by its insurance arm.²⁶ Simultaneously, the PBM can use its utilization management tools to steer patients who might have been prescribed the low-cost drug toward a higher-priced, higher-rebate alternative that is dispensed by its own specialty pharmacy.¹¹ This action sends a clear signal to the entire pharmaceutical industry: attempts to disrupt the high-rebate system will be met with market exclusion. This functions as a powerful “punishment strategy,” a key element required to sustain tacit collusion as described in economic game theory.⁴ The vertical integration provides the means to execute this punishment swiftly and effectively, ensuring all players adhere to the collusive equilibrium.

The GPO Shell Game: Centralizing Rebates and Obscuring Transparency

In recent years, the Big Three PBMs have introduced a new layer of complexity and opacity into the pharmaceutical supply chain: the PBM-affiliated Group Purchasing Organization (GPO). These entities, often referred to as “rebate aggregators,” represent a strategic evolution designed to further concentrate negotiating power, obscure the flow of rebate dollars, and circumvent growing demands for transparency and accountability from regulators

and plan sponsors.

The Rise of Rebate Aggregators

Responding to increasing scrutiny of their opaque rebate arrangements, each of the Big Three PBMs established a GPO to centralize the function of negotiating rebates with pharmaceutical manufacturers.²⁸ These entities are not traditional GPOs that purchase goods; they are contracting entities that aggregate the purchasing volume of their PBM members to extract larger price concessions from drug makers. The three key PBM-affiliated GPOs are:

- **Ascent Health Services:** Founded in 2019 by Express Scripts and strategically domiciled in Switzerland.³⁰
- **Zinc Health Services:** Founded in 2020 by CVS Caremark and domiciled in the United States.²⁹
- **Emisar Pharma Services:** Founded in 2021 by OptumRx and strategically domiciled in Ireland.³⁶

The Offshore Strategy: Circumventing U.S. Oversight

The decision by Express Scripts and OptumRx to establish their GPOs in Switzerland and Ireland is a deliberate strategic maneuver. These jurisdictions are well-known for their favorable corporate tax policies and financial privacy laws, making them ideal locations to shield the PBMs' most profitable activities from U.S. transparency laws, regulatory oversight, and tax liabilities.³⁹ The House Oversight Committee's investigation concluded that this move abroad "only heightens concerns that PBMs will do anything to avoid transparency".¹²

This offshore structure creates an impenetrable "black box" around rebate negotiations. It makes it nearly impossible for U.S.-based plan sponsors and regulators to conduct effective audits or trace the complete flow of rebate dollars from manufacturer to PBM.⁴⁰ By holding the rebate contracts in a separate, foreign-domiciled legal entity, the PBM can create legal and jurisdictional barriers that frustrate attempts at oversight.

This GPO structure is a direct and sophisticated response to the increasing fiduciary and transparency obligations being placed on plan sponsors and their vendors in the United States. The Employee Retirement Income Security Act (ERISA) imposes a strict fiduciary duty

on plan sponsors to act solely in the interest of plan participants, which includes ensuring that all plan expenses, such as prescription drug costs, are reasonable.⁴¹ More recently, the Consolidated Appropriations Act (CAA) of 2021 reinforced these duties by prohibiting "gag clauses" in PBM contracts and requiring PBMs to disclose detailed cost and compensation information to plan sponsors, precisely so they can fulfill their fiduciary duty of prudence.⁴⁵

Plan sponsors have a legal right to audit their PBMs to ensure compliance with these duties and contractual terms.⁴⁸ However, the offshore GPO structure is architected to defeat these rights. By placing the master rebate contracts with a foreign affiliate like Ascent in Switzerland, a PBM like Express Scripts can claim during an audit that it does not directly possess the contracts and therefore cannot produce them. This creates a shell game that erects an insurmountable wall of information asymmetry.⁵⁰ It makes it impossible for a plan sponsor to verify if they are receiving the best possible net price for drugs or if the PBM is truly acting in their best interest. This is not an incidental feature of the GPO model; it is a deliberate structural choice designed to neutralize the effectiveness of U.S. transparency and fiduciary laws.

GPOs as a New Layer of Profit Extraction

These GPOs have evolved beyond simple rebate negotiation to become new and opaque profit centers for their parent companies. They have created additional revenue streams by charging manufacturers a variety of fees, such as "administrative fees," "data access fees," and "enterprise fees," in addition to the rebates themselves.³⁴ These fees, charged as a percentage of the retail list price of a medication, which are often not clearly defined or disclosed, may not be fully shared with the PBMs' plan sponsor clients. This allows the PBM conglomerates to retain a larger portion of the total price concessions from manufacturers while maintaining the public-facing claim that they pass through "100% of rebates" to their clients.⁵⁴

The table below provides a comparative overview of the Big Three PBM-affiliated GPOs. It highlights their parent companies, founding dates, corporate domiciles, and known client bases. This comparison is essential for understanding the market dynamics, and it starkly illustrates the anomalous position of Ascent Health Services, which, unlike its peers, serves a broad consortium of PBMs, including direct competitors to its parent company. This

unique structure is a cornerstone of the tacitly collusive arrangement that governs the PBM market.

GPO Name	Parent PBM	Year Founded	Corporate Domicile	Known PBM Clients/Participants
Ascent Health Services	Express Scripts (Cigna)	2019	Switzerland	Express Scripts, Prime Therapeutics, Humana Pharmacy Solutions, Envolve Pharmacy Solutions, Kroger ²⁸
Zinc Health Services	CVS Caremark	2020	USA	CVS Caremark, Elevance Health's CarelonRx ²⁹
Emisar Pharma Services	OptumRx (UnitedHealth)	2021	Ireland	OptumRx ³⁶

A Framework for Tacit Collusion in the PBM Market

The behavior of the Big Three PBMs and their affiliated GPOs aligns closely with established economic and legal theories of tacit collusion. While there may be no evidence of a "smoky backroom" deal, their market conduct demonstrates a clear, unspoken understanding of their shared interests and a coordinated strategy to maintain supracompetitive prices. This section applies the theoretical framework of tacit collusion to the observable practices within the PBM market.

Market Conditions Favoring Collusion

The PBM market exhibits all the classic structural characteristics that are known to be conducive to tacit collusion:

- **High Market Concentration:** As established, the market is dominated by the Big Three, who control roughly 80% of prescription claims.¹ A small number of firms is the most critical factor, as it simplifies the process of monitoring rivals and coordinating

behavior.⁴

- **Repeated Interaction:** The business of PBMs and pharmaceutical manufacturers involves continuous, repeated negotiations over formularies and rebates. This ongoing interaction allows firms to learn each other's strategies, build reputations, and establish expectations of cooperative behavior. Game theory demonstrates that in such "repeated games," collusive outcomes are far more stable and likely to emerge than in one-off interactions, as the long-term benefits of cooperation outweigh the short-term gains from cheating.⁴
- **High Barriers to Entry:** The immense scale, deep vertical integration, and complex, opaque contracting models of the Big Three create formidable barriers to entry for new competitors.⁵ A new PBM cannot easily replicate the nationwide pharmacy networks, the vast claims processing infrastructure, or, most importantly, the negotiating leverage with manufacturers that the incumbents possess. This lack of a credible threat from new entrants allows the existing oligopoly to maintain its coordinated pricing strategies without fear of being undercut by a disruptive newcomer.

The Ascent Anomaly: A Monopoly Disguised as Competition

One of the most compelling pieces of evidence of a tacitly collusive arrangement among the Big Three PBMs lies in the unique and anomalous market structure of their affiliated GPOs. While the existence of three separate GPOs might initially suggest a competitive landscape, a closer examination of their client relationships reveals a carefully partitioned market. This structure points to an unspoken agreement to control a critical market segment, thereby neutralizing competitive threats from smaller PBMs.

The Façade of Competition

On the surface, the presence of three distinct GPOs—Ascent, Zinc, and Emisar—could be interpreted as a sign of competition in the rebate aggregation space. However, their operational models and client lists tell a different story. Zinc Health Services and Emisar Pharma Services function almost exclusively as "captive," in-house rebate aggregators for their parent companies, CVS Caremark and OptumRx, respectively.³⁵ While Zinc does have one other major client, Elevance Health's CarelonRx, this relationship is deeply intertwined, as

CarelonRx operates on a CVS technology platform.³⁵ There is no evidence to suggest that either Zinc or Emisar actively markets its rebate aggregation services to external, competing PBMs.

In stark contrast, Ascent Health Services operates on a fundamentally different model. It serves not only its parent, Express Scripts, but also a broad consortium of other PBMs and health plans. Its client list includes major industry players such as Prime Therapeutics (which is owned by a group of Blue Cross Blue Shield plans), Humana Pharmacy Solutions, and Kroger Prescription Plans.²⁸ This makes Ascent not just an in-house division of Cigna, but a market-wide utility for rebate negotiation.

Ascent as the Gatekeeper for Smaller PBMs

For the dozens of smaller and mid-sized PBMs that exist in the market, competing with the Big Three is an uphill battle. Their primary challenge is a lack of scale. Without the purchasing volume of tens of millions of covered lives, a smaller PBM cannot independently negotiate the substantial manufacturer rebates that are essential for offering competitive net drug costs to plan sponsors.⁸ Access to a rebate aggregator is therefore not a luxury but a necessity for survival.

The available evidence indicates that Ascent Health Services is the *only* major rebate aggregator that provides these smaller PBMs with a viable pathway to access these crucial manufacturer rebate contracts.²⁹ By joining the Ascent GPO, smaller PBMs can pool their volume with that of Express Scripts and its other large clients, thereby gaining the leverage needed to secure a portion of the market-leading rebates. The fact that Zinc and Emisar do not offer similar aggregation services to the broader market of competing PBMs is a critical and revealing market failure. It means that any smaller PBM seeking to compete effectively is forced to contract with a GPO that is owned and controlled by one of its largest competitors.

A Tacit Agreement to Not Compete

This highly unusual market structure is one of the strongest pieces of evidence of tacit collusion among the Big Three. The decision by CVS/Caremark and OptumRx to abstain from competing with Express Scripts in the market for third-party rebate aggregation services is a form of conscious parallelism that can only be explained by a shared understanding of their collective interest. It represents a tacit agreement to partition the market.

In what would be a presumably unspoken arrangement, CVS and OptumRx cede the market for smaller PBM rebate aggregation to Express Scripts. In return, Express Scripts, through its control of Ascent, ensures that the rebate negotiation strategies employed on behalf of these smaller players never disrupt the profitable, high-rebate, high-list-price equilibrium that benefits the entire oligopoly. Ascent will never secure a deal for a smaller PBM that would allow that PBM to genuinely undercut the Big Three on net drug costs. This arrangement effectively creates a monopoly within the oligopoly, with Ascent holding monopolistic power over the ability of smaller PBMs to access the lifeblood of their business: rebates.

This is not merely a monopoly; we argue it is a sophisticated and calculated market allocation designed to neutralize the primary threat to any oligopoly: a disruptive smaller competitor. The Big Three have effectively constructed a system to collectively suppress competition from the rest of the market. They tacitly agree that none of them will allow a smaller PBM to obtain a better rebate deal than they themselves receive. This is enforced by channeling all smaller competitors through a single gatekeeper—Ascent—which is controlled by one of their own.

Consequently, a small, innovative PBM that wishes to offer a transparent, low-net-cost model to employers cannot go directly to a manufacturer like Pfizer to negotiate a unique, favorable rebate contract. A manufacturer like Pfizer could be faced with retaliation in the form of loss of formulary position for contracting directly with a small PBM. The small PBM is thus forced to go through Ascent.²⁹ Ascent, being controlled by Express Scripts, has a powerful incentive to prevent any deal that would allow a smaller PBM to offer a lower net cost than Express Scripts, CVS, or Optum. This structure creates a "rebate wall" not just for certain drugs, but for an entire class of potential competitors. It explains how, despite the existence of over 70 PBMs in the U.S., the market remains fundamentally uncompetitive, locked in a state of coordinated inaction that preserves the opaque and profitable status quo for the dominant firms.⁶⁵

Section 4. Effects of Vertical Integration of Payers and PBMs

The PBM as the Primary Profit Center

The business goal of a large, publicly traded, vertically integrated firm is to maximize total corporate profit, not to minimize costs for any single division. An analysis of the public financial statements of these consolidated entities reveals that the PBM and other health services segments are the primary drivers of corporate profit, often generating significantly more absolute profit than the health insurance segment.

CVS Health presumably did not acquire Aetna for \$69 billion with the intention of making the Aetna health plan more efficient at the expense of the highly profitable CVS Caremark (PBM) and Retail Pharmacy segments. The strategic incentive is to use the Aetna health plan as a captive, locked-in customer for the parent company's higher-margin PBM and pharmacy services. This means the consolidated entity is incentivized to maximize the flow of dollars *through* the PBM, where profits are less regulated and more opaque, even if this increases the total cost burden on the health plan and its members. The corporate goal shifts from cost containment for the health plan to profit optimization across the entire enterprise.

Table 2: Revenue and Profit Contribution in Vertically Integrated Healthcare Companies (FY 2023)

Company	Business Segment	Segment Revenue (Billions)	Segment Adjusted/Operating Income (Billions)	Operating Margin %
UnitedHealth Group	UnitedHealthcare (Insurance)	\$281.4	\$16.4	5.8%
	Optum (Health Services)	\$226.6	\$15.9	7.0%
CVS Health	Health Benefits (Aetna)	\$105.6	\$6.9	6.5%
	Health Services (incl. Caremark)	\$187.0	\$7.2	3.9%
The Cigna Group	Cigna Healthcare (Insurance)	\$51.1	\$2.3	4.5%
	Evernorth (incl. Express Scripts)	\$153.6	\$6.5	4.2%

Source: Company FY2023 10-K Filings. Figures are based on adjusted or operating income as reported by each company.

While margins vary, the table clearly shows that the health services arms (Optum, Evernorth) are immense profit centers, with Evernorth generating nearly three times the absolute profit of Cigna’s insurance arm. This demonstrates where the corporate focus on profitability lies.

The Intra-Company Transfer Dynamic: Accounting for Internal Profits

From a consolidated accounting perspective, the financial impact of these PBM revenue streams is fundamentally different for a vertically integrated company compared to a non-integrated payer. For the latter, a PBM markup is a true external cost. For the former, it is an internal transfer of funds.

The principles of intercompany accounting mandate that for the purpose of creating consolidated financial statements for the parent company, transactions between subsidiaries must be eliminated.³⁰ This process is necessary to prevent the artificial inflation of revenue and expenses and to provide a true picture of the enterprise’s transactions with the outside world. When the insurance segment of a conglomerate pays its sister PBM segment, the payment is recorded as a cost (or “medical expense”) on the insurer’s books and as revenue on the PBM’s books. Upon consolidation at the parent level, this internal revenue and expense are netted out. The only true cost recognized by the consolidated entity is the amount that was ultimately paid to an external party—for example, the amount the PBM-owned pharmacy paid to a drug wholesaler.³⁰

Therefore, the “spread” charged by the PBM to its affiliated insurer is not a cost to the conglomerate but rather an accounting mechanism to allocate profit between its subsidiaries.¹³ The decision of how large to make the spread is a strategic one, driven not by market forces but by the parent company’s objectives for the reported financial performance of each segment, including, as will be discussed, regulatory compliance.

The following table illustrates the stark difference in the flow of funds and profit capture between a non-integrated and a vertically integrated system for a single drug transaction.

Table 1: Comparative Flow-of-Funds Analysis for a Prescription Drug Transaction

Transaction Step	Scenario A: Non-Integrated	Scenario B: Vertically
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	Payer	Integrated Payer
1. Pharmacy Acquisition Cost	Independent pharmacy pays wholesaler \$80.	PBM-owned pharmacy segment pays wholesaler \$80.
2. PBM Reimburses Pharmacy	External PBM pays independent pharmacy \$85.	PBM segment makes an internal payment of \$85 to the pharmacy segment.
3. Payer Pays PBM	Payer pays external PBM \$95 for the drug claim.	Insurance segment pays PBM segment \$95 for the drug claim.
Analysis of Profit Capture		
Pharmacy Profit	\$5 (Profit captured by an external company)	\$5 (Profit booked in the conglomerate's pharmacy segment)
PBM Profit ("Spread")	\$10 (Profit captured by an external PBM)	\$10 (Profit booked in the conglomerate's PBM segment)
Consolidated Financial Impact		
Payer's Net External Cost	\$95 (Cash leaves the payer's corporate entity)	\$80 (The conglomerate's only external cost is the payment to the wholesaler)
Total Profit Captured by External Parties	\$15 (\$5 pharmacy + \$10 PBM)	\$0
Total Profit Captured Internally	\$0	\$15 (\$5 pharmacy + \$10 PBM)

This comparison makes the internal economics clear. In Scenario A, the non-integrated payer incurs a real, external cost of \$95, and \$15 of profit is captured by outside firms. In Scenario B, the vertically integrated conglomerate's true external cost is only \$80. The \$15 in pharmacy and PBM profit does not leave the corporate entity; it is simply recorded in the ledgers of its various subsidiaries. The PBM markup, from the perspective of the parent company, is not a cost to be minimized but a profit to be maximized and strategically allocated.

The Medical-Loss Ratio (MLR) as a Regulatory Constraint

The financial strategies employed by vertically integrated payers operate within a specific and highly consequential regulatory framework established by the Affordable Care Act (ACA). The Medical-Loss Ratio (MLR) provision was designed to ensure that health insurers provide value to consumers by limiting the portion of premium revenue that can be allocated to administrative costs and profits. This regulation creates a clear dividing line between different

types of corporate expenditures, establishing a powerful incentive for insurers to classify as much spending as possible as "medical expense." Understanding the technical details of the MLR is crucial for appreciating how it can be manipulated through the internal financial mechanics of an integrated system.

Technical Breakdown of the MLR Calculation

The ACA's MLR rule is a statutory mandate that requires health insurance companies to spend a defined minimum percentage of their premium income on medical claims and activities that improve healthcare quality.³² If an insurer fails to meet this threshold, it must issue rebates to its enrollees.³⁴ The specific thresholds are set by market segment:

- **85%** for insurers in the large group market and for Medicare Advantage plans.³⁴
- **80%** for insurers in the individual and small group markets.³⁴

The MLR is calculated as a ratio with two key components: the numerator and the denominator.

- **The MLR Numerator** is the sum of an insurer's "incurred claims" and its expenditures on "activities that improve health care quality".³² Incurred claims represent the direct costs of providing clinical services and benefits to enrollees, including payments to doctors, hospitals, and for prescription drugs. The numerator explicitly excludes spending on administrative functions, such as marketing, executive salaries, profits, and general overhead.³²
- **The MLR Denominator** is the insurer's total premium revenue for the reporting year, adjusted by subtracting certain federal, state, and local taxes and licensing fees.³⁵

The fundamental structure of the MLR creates a powerful incentive for insurers. Every dollar of expenditure must be classified into one of two buckets: the "medical" bucket (the numerator), which helps the insurer meet the 80%/85% threshold, or the "administrative/profit" bucket, which is capped at 15%/20%. Any strategy that can successfully recharacterize a dollar from the administrative bucket to the medical bucket effectively frees up room in the 15%/20% portion for pure profit, without triggering the requirement to pay consumer rebates. This makes the accounting classification of expenses a critical area of financial management for insurers.

Regulatory Treatment of Pharmacy Costs, Rebates, and PBM Fees

Recognizing the significant and complex role of prescription drugs in healthcare spending, regulators at the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have issued specific guidance on how pharmacy-related costs are to be treated in MLR calculations.

- **Incurred Claims for Prescription Drugs:** The amount that an insurer can include in its MLR numerator for a drug claim is the net amount paid for the drug. This is intended to reflect the true cost of the benefit provided.
- **Mandatory Deduction of Rebates:** Federal regulations are explicit that all prescription drug rebates, discounts, and other price concessions must be deducted from an insurer's incurred claims.³⁸ Crucially, this applies to rebates received not only by the insurer itself but also by any of its third-party vendors, including its PBM.²⁷ This rule was designed to prevent insurers from inflating their medical costs by reporting the gross price of a drug while pocketing the rebate as profit.
- **Classification of PBM Spread and Fees:** In response to the growing use of spread pricing, CMS issued guidance in 2019 clarifying its treatment for MLR purposes in Medicaid managed care. The guidance explicitly states that the amount retained by a PBM through spread pricing is not a medical expense and must be excluded from the MLR numerator; it is to be treated as an administrative cost.³⁸ HHS has subsequently issued proposed rules to apply a similar principle to the commercial markets, requiring that any drug rebates or price concessions retained by PBMs be counted as administrative expenses for the health plan.⁴⁰

This evolving regulatory landscape demonstrates a clear pattern: as vertically integrated entities develop new and more complex methods for capturing profit through their PBMs, regulators are forced to react by issuing increasingly specific guidance to close the resulting loopholes. The initial MLR rule focused on rebates received by the insurer. Integrated firms exploited this by having the PBM—a legally separate subsidiary—retain the rebate or create a "spread," allowing the insurer to argue that it never received the funds and thus did not need to deduct them from its medical claims. The subsequent CMS guidance was a direct response to this regulatory arbitrage, showing that the financial structures of these conglomerates are often designed specifically to probe and exploit the seams in existing regulations.

Strategic MLR Management via Transfer Pricing

The convergence of vertical integration, the internal profit-center model of the PBM, and the regulatory constraints of the Medical-Loss Ratio creates the conditions for a sophisticated form of financial engineering. By manipulating the internal prices of goods and services exchanged between their subsidiaries—a practice known as transfer pricing—vertically integrated conglomerates can strategically manage their MLR calculations. This section details the core mechanism by which these entities inflate reported medical costs to ensure regulatory compliance while shifting profits to unregulated business segments.

The Transfer Pricing Loophole

Transfer pricing refers to the value assigned to transactions of goods or services between related entities within a larger enterprise.³⁰ In the context of an integrated payer, this is the price the insurance subsidiary (e.g., Aetna) pays its sister PBM and specialty pharmacy subsidiary (e.g., CVS Caremark) for prescription drugs dispensed to its members.

While accounting and tax standards generally require these internal prices to be set on an "arm's-length" basis—that is, at a price that two independent, unrelated parties would agree upon—this principle is exceedingly difficult to enforce in the uniquely opaque U.S. healthcare market.³⁰ Vertically integrated firms possess the ability and the incentive to set internal transfer prices not to reflect fair market value, but to optimize the financial and regulatory position of the consolidated enterprise.⁴³ The MLR rule, which applies to the insurance business but not to the PBM or pharmacy business, creates a powerful incentive to set these internal prices artificially high.

Inflating the Numerator: The Core Mechanism

The strategy for leveraging transfer pricing to manage the MLR is straightforward in its logic, though complex in its execution. It involves a deliberate over-payment between affiliated entities to reclassify profit as a medical expense.

1. **Setting the Inflated Price:** The parent company directs its PBM or specialty pharmacy subsidiary to charge its insurance subsidiary an artificially high price for a prescription drug. This is particularly effective with high-cost specialty drugs, where price

benchmarks are less established. For example, an integrated entity could set an internal transfer price of \$17,710 for a generic chemotherapy drug that its specialty pharmacy acquired for just \$72.⁴⁵

2. **Recording the "Medical Expense":** The insurance subsidiary pays this inflated price and records the full amount as an "incurred claim" on its financial statements. This payment, despite being an internal transfer within the conglomerate, is treated as a legitimate medical expense for the purpose of the MLR calculation, thus inflating the MLR numerator.⁴⁴
3. **Achieving MLR Compliance:** By swelling the numerator with these inflated internal costs, the insurer finds it much easier to meet or exceed the 80%/85% MLR threshold. This allows the insurer to avoid paying millions of dollars in consumer rebates and creates more room within the 15%/20% administrative and profit portion of the premium for other expenses or for declared profit.⁸

Profit Capture in Unregulated Subsidiaries

The key to this strategy is that the inflated portion of the transfer price does not simply vanish. The difference between the pharmacy's low acquisition cost and the high internal price paid by the insurer is captured as revenue and, ultimately, profit on the books of the PBM or specialty pharmacy subsidiary.⁸

Critically, these health services subsidiaries are not health insurers and are therefore **not subject to the MLR rule**. The profit they record is not constrained by the 15%/20% cap on administrative costs and profits that governs the insurance business.

The net result is a financial alchemy that transforms what would have been excess, rebate-triggering profit in the regulated insurance segment into fully compliant, unconstrained profit in the unregulated services segment. The conglomerate, as a whole, retains the same amount of money from the premium dollar, but it has been re-labeled and re-located on the corporate ledger to satisfy regulators. The MLR rule is technically met, but its core purpose—to ensure that a vast majority of the premium is spent on actual patient care and not retained as profit—is effectively defeated.⁸ "Medical cost," in this context, ceases to be an indicator of the economic resources used to provide care and instead becomes a fungible accounting variable to be optimized.

The following table provides a numerical illustration of this mechanism, comparing the

MLR outcomes for a non-integrated and a vertically integrated payer with identical underlying premium revenues and true medical costs.

Table 2: Comparative Medical-Loss Ratio (MLR) Calculation Scenarios

Line Item	Scenario A: Non-Integrated Payer	Scenario B: Vertically Integrated Payer
Denominator		
Premium Revenue	\$1,000,000	\$1,000,000
Numerator: Medical Costs		
Non-Drug Medical Claims	\$700,000	\$700,000
True Cost of Drugs (Paid to Pharmacy)	\$100,000	\$100,000 (Internal Cost to Pharmacy Seg.)
PBM Spread/Fees (External Cost)	\$20,000	N/A (Internal Transfer)
Inflated Transfer Price Paid to Own PBM/Pharmacy	N/A	\$160,000
Total Reported Medical Costs (Numerator)	\$820,000	\$860,000 (\$700,000 + \$160,000)
MLR Calculation (85% Threshold)		
Calculated MLR	82.0% (820,000/1,000,000)	86.0% (860,000/1,000,000)
Result	FAILS (Owes \$30,000 in Rebates)	PASSES (Owes \$0 in Rebates)
Consolidated Profit Analysis		
Insurer Profit	\$150,000 (Before Rebate)	\$140,000 (Profit in Insurer Seg.)
PBM/Pharmacy Profit	\$0 (Profit goes to external PBM)	\$60,000 (Profit in PBM/Pharmacy Seg.)
Total Conglomerate Profit	\$120,000 (After Rebate)	\$200,000 (\$140,000 + \$60,000)

As the table demonstrates, the vertically integrated payer, despite having the same underlying costs as the non-integrated payer, is able to report a compliant MLR and retain \$80,000 more in consolidated profit. This is achieved solely by using an internal transfer price for drugs that is \$60,000 higher than the true cost. This difference is booked as profit in the PBM/pharmacy segment, effectively hidden from the MLR calculation. This reveals that the MLR regulation, intended to limit insurer profits, paradoxically creates a powerful business case for the very vertical integration that allows the rule to be circumvented.

Evidence from Corporate and Regulatory Filings

The theoretical framework and mechanical models described in the preceding sections are not merely abstract concepts; they are reflected in the real-world financial reporting of major healthcare conglomerates and the findings of regulatory oversight bodies. An examination of corporate 10-K filings, state-level MLR audits, and federal investigations provides compelling evidence of these profit-shifting and MLR management strategies in action.

Analysis of Segment Reporting in Form 10-K Filings

The public financial statements of the largest integrated payers, while complex, offer a window into their internal economic structures. By analyzing the reported performance of their distinct business segments, a consistent pattern emerges.

- **UnitedHealth Group (UHG):** UHG's financial reports consistently show a stark contrast between its UnitedHealthcare (insurance) and Optum (health services) segments.⁴⁶ UnitedHealthcare generates hundreds of billions in revenue but operates on relatively thin operating margins, often in the low-to-mid single digits (e.g., margins ranging from 2.4% to 6.2% were reported in one quarter).⁴⁶ In contrast, the Optum platform, which includes the PBM OptumRx, reports robust growth and healthier margins. A critical line item in UHG's financial outlook is "Eliminations," which can represent sums exceeding \$160 billion.⁴⁶ This figure quantifies the massive scale of inter-segment transactions, a substantial portion of which represents payments from the regulated UnitedHealthcare segment to the less-regulated Optum segment for PBM, data, and clinical services.
- **The Cigna Group:** Cigna's filings reveal a similar dynamic between its Cigna Healthcare (insurance) and Evernorth Health Services (PBM and other services) segments.¹⁶ In 2024, Evernorth reported total revenues of over \$201 billion, dwarfing the \$53 billion reported by Cigna Healthcare. The filings also detail intersegment revenues, quantifying the billions of dollars flowing between the two platforms for pharmacy and care services.⁴⁸

The persistent pattern across these companies—lower operating margins in the MLR-regulated insurance segments and higher, more stable margins in the less-regulated health services and PBM segments—is the expected financial signature of a strategy that systematically uses internal transfer pricing to shift profits away from the constrained

insurance business.

Insights from State MLR Audits and Regulatory Reports

While corporate filings provide a high-level view, regulatory audits at the state level offer granular examples of how these inter-company transactions are scrutinized. These audits reveal the forensic accounting required to validate MLR reports submitted by health plans that subcontract with PBMs.

- **Case Study: Iowa MLR Audit:** An independent audit of a health plan's MLR calculation in Iowa provides a direct example of regulatory adjustment. In "Adjustment #7," auditors reduced the plan's reported incurred claims expense because its PBM, CVS Health, had assessed transaction fees on pharmacies. This meant the plan's reported expense, based on initial payments, was higher than the final net amount pharmacies actually received. The adjustment was made to reflect the true final payment to the pharmacy as the legitimate medical cost.⁵⁰
- **Case Study: New Hampshire MLR Audit:** An audit in New Hampshire found a discrepancy between the prescription drug rebates a health plan reported as a reduction to its claims and the amount its PBM, CVS, verified had been remitted to the plan. This forced an adjustment to the plan's incurred claims to align with the PBM's supporting documentation, highlighting the reliance on vendor attestations and the potential for misreporting.⁵¹

These state-level audits, while occasionally identifying and correcting discrepancies, often have limitations. They can verify that a payment from an insurer to its PBM was made and documented, but they may lack the regulatory framework or authority to challenge whether the *price* of that transaction was reasonable or set at an arm's-length basis. This points to a significant gap in oversight, where audits can ensure accounting consistency but not necessarily economic fairness or adherence to the spirit of the MLR.

Further substantiating the profit-shifting mechanism are the extensive investigations conducted by the Federal Trade Commission (FTC). The FTC's reports have provided powerful, data-driven evidence of the largest PBMs generating billions of dollars in revenue by imposing massive markups on specialty generic drugs dispensed through their own affiliated pharmacies.⁸ One report found that for the top 10 specialty generic drugs alone, these markups accounted for 12% of the aggregated operating income for the parent

conglomerates' PBM and pharmacy business segments in 2021.²⁰ These findings directly corroborate the transfer pricing strategy detailed in Section 4, where profits are systematically generated in the pharmacy and PBM segments through high prices charged to affiliated health plans and other sponsors.

Section 5. PBM Contracting is Compulsory not Strategic

The Formulary as a Gate and a Cudgel: PBM Leverage Over Pharmaceutical Manufacturers

The primary instrument of a Pharmacy Benefit Manager's power is the drug formulary. Far more than a simple list of covered medications, the formulary functions as both the ultimate gate to market access and a cudgel to enforce compliance from pharmaceutical manufacturers. Control over the formulary allows the handful of dominant PBMs to dictate which drugs are commercially viable and on what terms. This power is not merely used to negotiate discounts but is actively wielded to threaten manufacturers, block lower-cost competitors, and lock manufacturers into the PBM-centric rebate system, thereby precluding any possibility of establishing direct relationships with employers.

The Formulary as the Ultimate Gatekeeper

In a highly consolidated market, formulary placement is a matter of commercial life or death for a pharmaceutical product. By managing the benefits for approximately 80% of the insured population, the Big Three PBMs act as the gatekeepers to the vast majority of American patients.¹⁸ A manufacturer that fails to secure favorable placement for its drug on the formularies of CVS Caremark, Express Scripts, and OptumRx is effectively shut out of the market.²⁶ The extent to which a PBM can successfully steer physicians and patients toward its preferred formulary drugs can dramatically increase the sales and market share of those products.²⁹ This dependency gives PBMs immense leverage in their negotiations; manufacturers are not negotiating from a position of strength but are desperate for access to the PBM's massive patient base.²⁶ They must, therefore, acquiesce to the PBM's terms—including the payment of substantial rebates—to ensure their products can reach patients.

The Explicit Threat of Exclusion

The leverage afforded by formulary control is not abstract; it is used as an explicit threat. The FTC's investigation into the insulin market revealed a pivotal shift in PBM strategy around

2012. It was then that the major PBMs, "leveraging their size, began threatening to exclude certain drugs from the formulary to extract higher rebates from drug manufacturers".¹⁸ This marked the transformation of formularies from relatively open lists of covered drugs into powerful "exclusionary" tools of negotiation. A PBM can threaten to remove a manufacturer's drug entirely or relegate it to a "non-preferred" tier with prohibitively high patient cost-sharing, which effectively decimates its sales volume.³⁷ Faced with this credible threat, manufacturers have little choice but to comply with PBM demands for larger rebates, which, as previously established, often requires them to raise their list prices. This dynamic creates a coercive environment where the PBM dictates terms, and the manufacturer's primary goal becomes avoiding the catastrophic financial consequences of formulary exclusion.

This power dynamic creates a scenario that effectively prevents manufacturers from entertaining alternative arrangements, such as direct-to-employer rebate programs or employer net pricing. For any major pharmaceutical manufacturer, the business calculus is stark. The potential revenue gain from a direct deal with even a very large single employer is dwarfed by the potential revenue loss that would result from PBM retaliation. If a manufacturer were to engage in a direct deal, it would signal to the PBMs that their essential gatekeeper role can be circumvented. To protect their highly profitable business model, the PBMs would have a powerful incentive to make an example of that manufacturer. They could demote the manufacturer's entire portfolio of drugs across their national books of business, costing the company billions of dollars in lost sales. The rational and unavoidable choice for the manufacturer is to refuse any direct deal and continue to operate within the confines of the PBM-controlled system. This strategic reality, born from the PBM's absolute power over the formulary, is the ultimate lock-in mechanism that perpetuates the current market structure.

Exclusionary Rebates and Blocking Competition

PBMs wield their formulary power not only to extract rebates but also to actively stifle competition, particularly from lower-cost generic and biosimilar drugs. Evidence gathered by the FTC and other industry observers shows that PBMs and brand-name manufacturers often negotiate rebate contracts that are *expressly conditioned* on the PBM limiting access to, or completely excluding, less expensive competitor products from the formulary.⁸

This practice of "exclusionary rebates" serves the financial interests of both the brand

manufacturer, who protects its market share from generic erosion, and the PBM, who secures a large rebate stream from the high-priced brand drug. However, it directly harms the employer and the healthcare system as a whole by blocking access to significant cost savings. The slow market uptake of biosimilars—near-identical and cheaper versions of complex biologic drugs—is a clear consequence of this tactic. For example, despite the launch of multiple biosimilars to Humira, one of the world's best-selling drugs, many PBMs continued to grant preferential formulary status to the high-rebate brand-name version, thereby limiting patient and payer access to the lower-cost alternatives.³ This practice demonstrates that the formulary is used not to promote cost-effectiveness but to protect lucrative rebate arrangements, further cementing the PBM's role as a gatekeeper that prioritizes its own revenue over the financial interests of its clients.

The Unbreachable Wall: Why Direct Employer-Manufacturer Contracting Remains Untenable

For employers seeking to escape the opaque and costly PBM-centric system, the logical alternative would appear to be direct negotiation with pharmaceutical manufacturers. However, a formidable and, for all practical purposes, unbreachable wall prevents such arrangements from becoming a reality. This wall is constructed from three mutually reinforcing barriers: an insurmountable deficit in negotiating leverage, a prohibitive lack of administrative infrastructure, and a powerful gatekeeper lockout enforced by manufacturers' rational fear of PBM retaliation. The interplay of these factors ensures that employers remain captive to the PBM model, not by choice, but by the complete absence of a viable alternative.

The Leverage Deficit - The Myth of Employer Scale

The foundation of a PBM's negotiating power is its immense scale. A PBM negotiates rebates not on behalf of a single employer, but on behalf of tens of millions of "covered lives" aggregated from thousands of employer and health plan clients.²⁶ A manufacturer's willingness to offer a substantial rebate is directly proportional to the volume of sales that a PBM can guarantee through its control of formulary placement.²⁸ No single employer, not even the largest multinational corporations, can command a patient population that comes close to matching the scale of one of the Big Three PBMs.

An individual employer, therefore, enters any hypothetical direct negotiation from a

position of profound weakness. The volume it can offer a manufacturer is a fraction of what a PBM can offer, meaning any potential rebate would be correspondingly smaller. The manufacturer has little incentive to create a bespoke, one-off contract with a single employer when it can achieve far greater market access and efficiency through its existing arrangements with the dominant PBMs. The PBMs' aggregation of purchasing power creates a leverage differential that an individual employer simply cannot overcome.

The Gatekeeper Lockout - Manufacturer Risk Aversion

The final and most decisive barrier is the gatekeeper lockout, a direct consequence of the PBM's formulary power as detailed in the previous section. Even if an employer could somehow overcome the leverage and infrastructure hurdles—perhaps by forming a large coalition of other employers—they would still face the insurmountable obstacle of manufacturer risk aversion.

As established, manufacturers are locked into the PBM system by the credible threat of retaliatory formulary exclusion. The financial risk of being demoted or removed from the formularies of the Big Three PBMs, and thereby losing access to up to 80% of the insured market, is simply too catastrophic to contemplate. The potential gain from a direct deal with one employer or even a coalition of employers cannot justify jeopardizing the company's primary channel to the market. This creates a powerful disincentive for any manufacturer to pioneer an alternative distribution model. The PBMs have successfully structured the market in such a way that it is in every manufacturer's individual self-interest to refuse direct contracting and perpetuate the PBM-centric system.

These three barriers—leverage, infrastructure, and lockout—are not independent but are mutually reinforcing. The PBMs' control over the administrative infrastructure solidifies their negotiating leverage, and their immense leverage gives them the power to enforce the gatekeeper lockout. This interlocking system creates a fortress around the PBM business model that employers cannot breach. It is this systemic lock-in that proves employers contract with PBMs not for the value they provide, but from a complete and total lack of any other viable path to providing a pharmacy benefit to their employees.

Section 6. PBM Margins are Significantly Higher When Calculated Based on Net Drug Costs

The theoretical argument that PBM margins are significantly higher when measured against net costs is validated by empirical data. A comprehensive 2024 report prepared by the Eastern Research Group (ERG) for the HHS Assistant Secretary for Planning and Evaluation (ASPE) provides the most direct quantitative evidence by modeling the flow of payments and calculating intermediary margins as a percentage of net sales.¹

The key findings from the ASPE/ERG report for the year 2022 are summarized in Table 2 and detailed below:

- **Overall PBM Margin:** The analysis concluded that PBMs captured the highest profit margins among all supply chain intermediaries. In 2022, total PBM margins were estimated at **\$60.6 billion**, which represented **31.2%** of total net expenditures on retail prescription drugs.¹ This figure provides a powerful, system-wide confirmation that PBM profits constitute a substantial portion of the final net cost paid for medications.
- **PBM Margin Growth:** The report also found that PBM margins are growing rapidly. The PBM margin percentage on net sales increased from 23.1% in 2020 to 24.5% in 2021, before jumping to 31.2% in 2022. This growth was attributed in part to rising pharmacy DIR fees, which increased by an estimated 46.8% from 2020 to 2022, effectively transferring margin from pharmacies to PBMs.²
- **Brand vs. Generic Drug Margins:** The ASPE/ERG report reveals a crucial distinction in how PBMs derive profit from brand versus generic drugs:
 - **Brand Drugs:** PBMs earned a total margin of **\$30.7 billion** from brand drugs, which represented a **22.2%** margin percentage on net sales.²
 - **Generic Drugs:** PBMs earned a total margin of **\$29.9 billion** from generic drugs, representing a staggering **53.6%** margin percentage on net sales.³⁸

These figures highlight a paradox that reveals the sophistication of PBM business strategy. While the margin *percentage* on generics (53.6%) is more than double that of brands (22.2%), the total *dollar amount* of profit earned from each category is nearly identical (\$29.9 billion vs. \$30.7 billion). This is because PBMs employ different primary profit models for each drug type. For low-cost generics, where manufacturer rebates are rare, the dominant profit driver is **spread pricing**—charging the health plan a price far exceeding the amount paid to the

pharmacy.³ The high 53.6% margin reflects this large spread relative to the low net cost of the generic drug. For high-cost brand drugs, the primary profit driver is the retention of a portion of the large manufacturer **rebates**, which are tied to the drug's high list price.⁴ Even though the 22.2% margin percentage is lower, it is applied to a much larger net cost base, resulting in a high dollar profit per prescription. This dual-strategy approach allows PBMs to effectively maximize revenue across the entire pharmaceutical landscape.

These findings can be contextualized with other research, such as the Schaeffer Center's "Flow of Money" analysis, which estimated an average PBM gross margin of 6%.⁴ The discrepancy is likely due to methodological differences. The Schaeffer analysis relied heavily on publicly traded companies' financial filings, which may use revenue recognition methods that obscure drug-level profitability—for instance, by counting the full value of all contracted drugs as revenue, which would artificially lower the perceived margin percentage.⁵ The ASPE/ERG report's methodology, which models margins on a per-drug basis relative to net sales, provides a more granular and direct measure of PBM profitability on the underlying drug transactions.

Section 7. Statistical Dynamics of Rebate Distributions

The Congressional Budget Office (CBO) serves a vital and indispensable function within the United States legislative process. As a non-partisan entity, its analyses and cost estimates—colloquially known as “scores”—provide the fiscal framework upon which federal legislation is debated, amended, and ultimately enacted.¹ The credibility of these scores, and by extension the informed nature of the policy-making process, rests not only on the CBO’s objectivity but also on the structural integrity and theoretical soundness of its underlying economic models. The assumptions embedded within these complex models are not mere technical details; they are foundational judgments that can profoundly alter budgetary projections, shape the perceived viability of policy interventions, and direct legislative attention toward certain problems while obscuring others. An inaccurate assumption can lead to flawed policy, misallocated resources, and a failure to address the true drivers of systemic costs.

This report presents a critical examination of one such foundational assumption believed to inform the CBO’s modeling of the pharmaceutical market: the characterization of the probability distribution of manufacturer rebates. It is understood that the CBO’s analytical framework may presume that this distribution exhibits a rightward, or positive, skew. The logic underpinning this assumption appears to be rooted in two observations: first, that rebates have a natural lower bound of 0%; and second, that the opaque nature of rebate negotiations introduces significant variance into the system.³ In this view, the increased standard deviation manifests as a long right tail, representing a minority of exceptionally high rebates that pull the overall average upward. This assumption carries significant weight, as it influences estimates of federal savings from policies designed to alter drug pricing, such as government price negotiation or rebate reform.⁴

The central thesis of this report is that the assumption of a positively skewed rebate distribution is not only empirically unsubstantiated but also theoretically weak when confronted with the structural and economic realities of the U.S. pharmaceutical market. This analysis will construct a comprehensive, evidence-based argument for an alternative hypothesis: that the distribution of pharmaceutical rebates is, in fact, more plausibly characterized by a leftward, or negative, skew. This counter-hypothesis fundamentally alters the understanding of drug pricing dynamics, the efficacy of rebate negotiations, and the likely

impact of policy interventions.

The argument presented herein is built upon three core pillars. First, it establishes that an "empirical impasse" exists due to the systemic and legally protected confidentiality of all drug-specific rebate data. In the absence of direct evidence, any assumption about the distribution's shape is inherently speculative and must be judged on its theoretical and logical coherence. Second, it advances a robust theoretical and economic case for a negatively skewed distribution. This case is grounded in the statistical properties of a distribution that is bounded at both 0% and 100% and is supported by compelling proxy data from the highly competitive generic drug market, where mean discounts are concentrated at exceptionally high levels. Third, the report introduces a critical distinction between "gross" and "effective" rebates, demonstrating how the fee structures of market intermediaries, particularly Pharmacy Benefit Managers (PBMs), systematically erode the value of negotiated rebates. This erosion disproportionately affects high-rebate drugs, further intensifying the leftward skew of the distribution that is truly relevant to net costs and federal outlays.

This report will proceed by systematically deconstructing the positive skew assumption and building the case for the negatively skewed alternative. It will begin by detailing the profound opacity of the rebate market, then move to a theoretical reassessment of distributional dynamics, followed by an empirical analysis using the generic market as a proxy. It will then analyze the distorting impact of intermediary fees before concluding with a synthesis of the findings and their implications for the CBO and for federal policymaking.

The Empirical Impasse: Unknowable Distributions in an Opaque Market

Any attempt to model the distribution of pharmaceutical rebates confronts an immediate and insurmountable obstacle: a complete absence of the granular, drug-specific data required for such an analysis. This is not an accidental data gap or a temporary limitation of research; it is a structural and legally reinforced feature of the U.S. pharmaceutical market. The assumption of a rightward skew, or indeed any distributional shape, is therefore an exercise in conjecture, as it cannot be empirically verified or falsified with publicly available information. Understanding the depth and rationale of this opacity is the first step in demonstrating why theoretical coherence and logical consistency, rather than unavailable data, must be the primary criteria for evaluating the CBO's modeling assumptions.

The Contractual and Statutory Wall of Confidentiality

At the heart of the empirical impasse are the contractual agreements between pharmaceutical manufacturers and PBMs. Drug-specific rebate amounts are considered proprietary trade secrets and are fiercely protected by confidentiality clauses within these contracts.⁹ This confidentiality serves the commercial interests of both parties, preventing competitors from gaining insight into pricing strategies and negotiation outcomes. Payers, such as commercial health plans and employers, often have limited ability to assess the true cost savings generated on a per-drug basis, particularly if their contracts with PBMs guarantee only aggregate rebate levels rather than drug-specific pass-throughs.⁹

This commercial practice is frequently reinforced by statutory law. State governments, which negotiate their own supplemental rebates for Medicaid programs, often enact laws that explicitly shield this information from public view. A clear example is Texas Government Code Section 531.071, which mandates that "information obtained or maintained by the commission regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under state public information law."¹¹ This legal framework creates a formidable barrier to independent analysis, ensuring that the precise values needed to plot a distribution remain hidden.

The Economic Rationale for Secrecy

The persistence of this opacity is not without a compelling economic rationale, which is often advanced by industry stakeholders and has been acknowledged by regulatory bodies. The primary argument is that confidentiality is a prerequisite for vigorous price competition.³ In an opaque market, a manufacturer can offer a substantial, secret rebate to a PBM to win preferential formulary placement, thereby gaining market share at the expense of its rivals. Competitors, unaware of the exact discount offered, are forced to compete aggressively to match or exceed it.

Conversely, in a fully transparent market, this competitive dynamic could be blunted. The Federal Trade Commission (FTC) has warned that public disclosure of rebate values could facilitate "tacit collusion," a scenario where manufacturers could monitor each other's net pricing and coordinate their behavior without explicit agreement, leading to smaller rebates

and higher overall prices.¹⁹ A Milliman analysis modeled the potential impact of public disclosure requirements in Medicare Part D, estimating that a 15% reduction in manufacturer rebates could result, leading to a \$134 billion increase in federal costs over ten years.¹⁹ The CBO has echoed this concern, stating that disclosure "would probably make rebates less varied" and "facilitate tacit collusion among the manufacturers of competing brand-name drugs".³

While this rationale explains the persistence of confidentiality, it also contains the seeds of a contradiction for the positive skew assumption, which will be explored in the next section. For now, it suffices to establish that the market is structurally designed to be opaque. This systemic opacity is more than just a barrier to analysis; it is a core feature of the PBM business model. It creates a significant information asymmetry that benefits intermediaries. By negotiating confidential gross rebates, PBMs can demonstrate substantial "savings" off the list price to their clients (payers) while simultaneously obscuring the portion of that value they retain through various fees and pricing spreads. The lack of data is not a neutral market condition but a strategic element that reinforces the value proposition of the intermediary, regardless of the effective net savings passed through.

In this evidence vacuum, any model of the rebate distribution is an unfalsifiable hypothesis. Therefore, the burden of proof must shift from empirical demonstration to theoretical and economic plausibility. The following sections will argue that the theoretical underpinnings of a negatively skewed distribution are far more robust and consistent with the observable dynamics of the pharmaceutical market.

A Theoretical Reassessment of Rebate Distribution Skewness

In the absence of empirical data, the validity of any assumption about the shape of the pharmaceutical rebate distribution must be judged on its theoretical and economic foundations. The presumed CBO logic for a positive skew rests on a standard, yet incomplete, statistical interpretation that fails to account for the unique constraints and competitive dynamics of the drug pricing market. A more rigorous analysis, incorporating the full context of the market, reveals that the CBO's own premises about market opacity and competition lead logically to the conclusion of a negative, not positive, skew.

Deconstructing the Positive Skew Argument

The argument for a positive (rightward) skew is typically based on the properties of distributions with a fixed lower bound. In statistics, variables that cannot be negative, such as income or failure times in reliability studies, often exhibit a rightward skew.²⁰ This occurs because while values are constrained at zero, there is no theoretical upper limit, allowing for a long tail of extremely high outlier values that pull the mean above the median.²²

The CBO's presumed logic appears to apply this general principle to pharmaceutical rebates. Rebates, expressed as a percentage of the list price, have a hard lower bound of 0%. The CBO has also argued that the opacity of the market increases the standard deviation of rebates, creating greater variation in negotiated outcomes.³ The implicit conclusion is that this increased variance stretches the distribution to the right, creating a long tail of exceptionally large rebates successfully negotiated by PBMs for a subset of drugs. This tail of high-value outliers would, in theory, pull the mean rebate upward and produce the characteristic positive skew. While this logic is superficially plausible, it omits a critical market feature and misinterprets the economic effect of opacity.

The Overriding Influence of a Bounded Distribution (0% to 100%)

The most significant flaw in the positive skew argument is its failure to account for the fact that the rebate distribution is bounded on *both* sides. A rebate, as a percentage of list price, cannot be less than 0%, but it also cannot exceed 100%. This upper bound fundamentally alters the statistical possibilities for the distribution's shape.

For any probability distribution that is bounded on two sides, a strong relationship exists between the mean, the bounds, and the direction of the skew. If the mean of the distribution is located significantly closer to one bound than the other, the distribution is mathematically constrained to be skewed in the opposite direction. The "long tail" of the distribution must, by necessity, extend toward the more distant bound to balance the concentration of mass near the closer bound.³

This principle is the theoretical cornerstone of the negative skew hypothesis. If, as evidence from the generic market proxy strongly suggests (detailed in Section 4), the mean rebate for brand-name drugs is high—for example, well above the midpoint of 50%—then the mass of the distribution is concentrated near the upper 100% bound. To accommodate this, the distribution must have a long tail extending toward the lower 0% bound. This is the

definition of a negative (leftward) skew, where the mean is pulled below the median by a tail of low-value outliers.²² Therefore, the central question is not about the existence of a lower bound, but about the location of the mean relative to both the lower and upper bounds.

Economic Drivers of a High Mean and Negative Skew

Shifting from pure statistics to market economics reinforces the case for a high mean and, consequently, a negative skew. The primary driver of rebate magnitude is the level of competition within a given therapeutic class.² PBMs leverage this competition to extract price concessions from manufacturers. For a drug in a crowded therapeutic class (e.g., insulins, anti-inflammatory drugs, statins), the manufacturer faces a stark choice: offer a substantial rebate to secure a preferred position on the PBM's formulary or risk being placed on a high-cost-sharing, non-preferred tier or being excluded entirely, leading to a catastrophic loss of market share.

This intense competitive pressure forces most manufacturers within such classes to offer similarly large rebates. This dynamic creates a large cluster of data points at the high end of the rebate spectrum (e.g., in the 60% to 95% range). The "tail" of the distribution, in this economic reality, is not composed of exceptionally high rebates but of exceptionally low ones. These low-rebate drugs are typically those that face little to no direct competition. This includes products with a unique mechanism of action, drugs for rare or orphan diseases, or newly launched products still under market exclusivity. For these drugs, manufacturers possess significant pricing power and have little incentive to offer large rebates.

The resulting distribution is therefore characterized by a large mass of drugs with high rebates, clustered near the upper bound, and a long, sparse tail of low-rebate drugs extending toward the 0% bound. This is the classic profile of a negatively skewed distribution.

The Generic Market: An Empirical Window into Discount Distribution

Given the complete unavailability of brand-name rebate data, any empirical grounding for distributional assumptions must rely on a suitable proxy. The U.S. generic drug market, while distinct from the brand market in important ways, offers the most compelling and data-rich analogue for observing the effects of intense price competition on a distribution of discounts. The evidence from this market is overwhelming: it is characterized by extremely high average discounts, with the vast majority of products clustering at the highest end of the

discount spectrum. This provides powerful empirical support for the hypothesis that a competitive pharmaceutical market naturally produces a negatively skewed distribution of price concessions.

Justifying the Generic Market as a Valid Proxy

The validity of using the generic market as a proxy rests on the similarity of the underlying competitive dynamic that drives price reductions. The generic market is defined by multiple manufacturers producing clinically equivalent products and competing almost exclusively on price.²⁷ This mirrors the dynamic in brand-name therapeutic classes where several drugs with similar clinical profiles compete for formulary placement, forcing manufacturers to use rebates as their primary competitive tool.²⁸ In both scenarios, buyers (wholesalers and PBMs for generics, PBMs for brands) leverage the presence of multiple sellers to drive the net price down.

It is essential to acknowledge the limitations of this proxy. The brand market involves product differentiation, patent protection, and significant marketing expenditures, which are largely absent in the generic space. Furthermore, brand rebates are typically negotiated post-sale and are retrospective, whereas generic discounts are often reflected in the upfront acquisition price.²⁶ However, for the specific purpose of modeling the *shape* of the resulting distribution of price concessions, these differences are less critical than the shared feature of intense, multi-player price competition. The generic market provides a transparent view of how a distribution of discounts behaves under the competitive pressures that PBMs are designed to create in the brand market.

Synthesizing the Data on Generic Discounts

A vast body of research from government agencies and academic institutions documents the profound impact of competition on generic drug prices. The U.S. Food and Drug Administration (FDA) and the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) have consistently found that generic prices fall precipitously as the number of competitors increases.²⁹

The data paints a clear and consistent picture:

- **Limited Competition:** With only one generic manufacturer, prices are often only modestly lower than the brand price. An FDA analysis found a single generic competitor

reduced prices by just 39% relative to the pre-entry brand price.³³

- **Moderate Competition:** The introduction of even a few competitors has a dramatic effect. ASPE analysis shows that with about three competitors, prices decline by 20% to 40%.³¹ With four competitors, the FDA finds that prices are, on average, 79% lower than the brand price.³³
- **Intense Competition:** As the number of competitors grows, prices are driven down toward what is presumed to be the marginal cost of production. In markets with six or more competitors, FDA data shows price reductions of more than 95% compared to the brand price.³³ Similarly, ASPE finds that in markets with 10 or more competitors, prices decline by 70% to 80% or more.³¹

A 2022 FDA report on savings from new generic approvals highlighted that several products experienced price declines of more than 80%.³⁵ For example, the generic version of Lurasidone Hydrochloride (Latuda) saw its price fall by 96% in the 12 months after generic approval.³⁵ This evidence overwhelmingly indicates a distribution where the mean discount is extremely high and the vast majority of data points for multi-source generics are concentrated in the 80% to 100% discount range.

Visualizing the Negative Skew

To translate these findings into a clear distributional form, the data can be collated into a frequency distribution table. While the exact number of products in each bracket requires a comprehensive meta-analysis, the existing literature allows for a robust, illustrative representation of the distribution's shape.

Table 1: Illustrative Frequency Distribution of Generic Drug Price Reductions vs. Pre-Entry Brand Price

Discount Bracket	Concentration of Products	Supporting Evidence
0-20%	Very Low (Primarily single-source or duopoly markets)	Price reductions are minimal with only one competitor. ³³
20-40%	Low (Markets with ~3 competitors)	Prices decline by 20-40% with 3-5 competitors. ³¹
40-60%	Moderate (Markets with ~2-3 competitors)	With two competitors, prices are ~54% lower than brand. ³³

60-80%	High (Markets with 4+ competitors)	Prices are ~79% lower with four competitors ³³ ; 70-80% lower with 10+. ³¹
80-100%	Very High (Majority of highly competitive markets)	Price reductions exceed 95% with six or more competitors. ³³ Multiple products see >80% declines. ³⁵

This distribution is unambiguously skewed to the left (negatively skewed). The mass is heavily concentrated at the far-right end of the scale, with a long, sparse tail extending to the left, representing the minority of generic drugs in markets with limited or no competition.

This empirical picture from the generic market has profound implications. It suggests that where competition is allowed to flourish, the U.S. system is exceptionally effective at extracting deep discounts. This is further supported by the paradoxical finding that while U.S. brand-name drug prices are, on average, 3.2 to 4.2 times higher than in other developed countries, U.S. prices for unbranded generics are significantly *lower*, averaging just 67% of the prices in those same nations.³⁶ This demonstrates that the mechanisms for competitive price reduction in the U.S. are powerful. It is therefore highly plausible that in the competitive segments of the brand-name market, the rebate-negotiating mechanism should be similarly effective, producing the very high rebates that would result in a negatively skewed distribution.

The Hidden Costs: How Intermediary Fees Reshape the Effective Rebate Distribution

The analysis thus far has focused on the "gross rebate"—the total price concession offered by a manufacturer. However, from the perspective of a payer, such as the federal government or a commercial health plan, this figure is an incomplete and often misleading metric of cost reduction. The final net cost is determined by the "effective rebate," which is the gross rebate minus all fees and revenue retained by intermediaries, principally PBMs. An examination of PBM compensation models reveals that their fee structures, which are often linked to a drug's list price, systematically erode the value of rebates. This process not only reduces overall savings but also reshapes the underlying distribution, transforming the already negatively skewed gross rebate distribution into an even more intensely compressed and left-skewed effective rebate distribution. Any budgetary model that fails to account for

this distinction is modeling the wrong variable and will inevitably overestimate savings.

The Architecture of PBM Compensation

PBMs are compensated through a complex and often opaque array of revenue streams that go far beyond a simple administrative fee for processing claims.⁷ Understanding these mechanisms is crucial to calculating the effective rebate. The primary sources of PBM revenue include:

- **Rebate Retention:** PBMs negotiate rebates with manufacturers and typically pass through a majority of these funds to the plan sponsor. However, they often retain a percentage of the rebate as compensation for their negotiation services.³⁸ While PBMs report that 91% of rebates are passed on to commercial insurers, this figure is an aggregate and may not apply to all payers, and the retained portion represents a direct reduction in the rebate's value.⁷
- **Administrative Fees:** PBMs charge payers administrative fees for their services. Critically, these fees are not always flat, per-member-per-month charges. They can be structured as a percentage of the drug's list price (Wholesale Acquisition Cost, or WAC) or on a per-script basis that varies by drug type.⁶ This structure creates a direct link between the PBM's revenue and the list price of the drugs being dispensed.
- **Spread Pricing:** Particularly in the context of generic drugs, PBMs can engage in "spread pricing," where they charge the health plan a higher price for a drug than they reimburse the dispensing pharmacy. The PBM retains the difference, or "spread," as profit. This practice has generated billions in revenue for the largest PBMs and represents another form of value capture that is not reflected in rebate figures.⁷
- **Other Fees:** Manufacturers may pay PBMs additional fees for services such as data provision, educational programs, or securing favorable formulary placement, which may not be classified as rebates but still represent a flow of funds from manufacturer to PBM that influences net costs.⁴¹

The Perverse Incentive of High-List, High-Rebate Drugs

The practice of linking PBM administrative fees to a drug's list price creates a significant conflict of interest that can inflate costs for the entire system. Because the PBM earns more

revenue from a higher-priced drug, it has a financial incentive to favor drugs with high list prices and correspondingly high rebates on its formularies, even if a therapeutically similar alternative with a lower list price and lower rebate would result in a lower net cost to the payer.³⁸

This dynamic pressures manufacturers to set high list prices to accommodate the PBMs' demand for large rebates, from which PBMs can extract greater fee-based revenue. Research from the USC Schaeffer Center has established a direct statistical link, finding that, on average, a \$1 increase in rebates is associated with a \$1.17 increase in list prices.⁴⁴ This finding strongly suggests that PBMs' demand for rebates is a significant driver of list price inflation. Manufacturers are compelled to raise list prices to fund the very rebates that are supposed to control costs, creating a circular and inflationary dynamic that benefits the intermediary.

Modeling the Leftward Shift of the Effective Rebate

The cumulative impact of these fees is to create a substantial wedge between the gross rebate and the effective rebate. This can be defined as follows:

- **Gross Rebate %** = (Rebate from Manufacturer in \$) / (List Price in \$)
- **Effective Rebate %** = (Rebate from Manufacturer in \$ - All PBM Fees & Retained Revenue in \$) / (List Price in \$)

Since PBM fees are a non-zero cost, the effective rebate percentage will always be lower than the gross rebate percentage. Furthermore, because these fees are often larger in absolute terms for drugs with higher list prices (which are also typically the drugs with the highest gross rebates), the reduction is not uniform across the distribution. The value of high rebates is eroded more significantly than the value of low rebates.

This dynamic has a clear and predictable impact on the shape of the distribution. It takes the entire right-hand side of the gross rebate distribution—where the high-rebate drugs are clustered—and pulls it to the left. This action compresses the distribution toward the lower end of the scale and makes the existing negative skew even more pronounced.

The following table provides a simplified but powerful illustration of this effect, modeling a PBM fee calculated as a percentage of the list price.

Table 2: Illustrative Model of Gross vs. Effective Rebate Distributions

Drug Profile	List Price	Gross Rebate %	Gross Rebate (\$)	PBM Fee (e.g., 3% of List Price)	Effective Rebate (\$) (Gross \$ - Fee \$)	Effective Rebate %
Drug A (Low Rebate/Low Price)	\$200	10%	\$20	\$6	\$14	7.0%
Drug B (Medium Rebate/Price)	\$500	50%	\$250	\$15	\$235	47.0%
Drug C (High Rebate/High Price)	\$1,000	80%	\$800	\$30	\$770	77.0%

As the model demonstrates, the PBM fee reduces the rebate percentage for all drugs. However, the effect is most significant in terms of the policy narrative surrounding high-rebate drugs. While Drug C still has a high effective rebate of 77%, the 3-percentage-point reduction represents a significant transfer of value (\$30) to the intermediary that is obscured if one only considers the 80% gross rebate figure. When applied across the entire pharmaceutical market, this systematic reduction shifts the entire distribution leftward.

This analysis reveals that the very concept of a single "rebate distribution" is a critical oversimplification. There are at least two distinct distributions: the **gross rebate distribution** (reflecting manufacturer-to-PBM transactions) and the **effective rebate distribution** (reflecting the net value passed to the payer). The CBO's models are likely based on the former, as it is relevant to manufacturer revenue and easier to estimate from their nonpublic data. However, it is the latter distribution that is directly relevant to federal spending, deficits, and the true cost of prescription drugs. By focusing on gross rebates, any model fails to capture the significant value extracted by intermediaries and thus mischaracterizes the true financial landscape. This mischaracterization has profound policy implications, suggesting that the most effective legislative levers may not be those that target the size of gross rebates, but rather those that reform the structure of intermediary compensation to "delink" PBM revenue from inflationary list prices.⁶

Summary of the Case Against Positive Skew

The argument against a positively skewed rebate distribution is multi-layered and compelling:

- **It is Empirically Unverifiable:** The foundational argument is that the market is structurally and legally opaque. Drug-specific rebate data is confidential trade secret information, making it impossible to directly plot or verify any distributional shape.⁹ In this evidence vacuum, assumptions must be held to a higher standard of theoretical and logical soundness.
- **It is Theoretically Weak:** The positive skew argument rests on an incomplete statistical premise, focusing on the 0% lower bound while ignoring the equally important 100% upper bound. For a bounded distribution, a high mean—driven by intense competition for formulary placement—mathematically necessitates a negative skew, with a long tail of low-rebate monopoly drugs extending toward the 0% bound.²¹ Furthermore, the CBO's own premise that market opacity prevents collusion and thereby intensifies competition provides a direct economic rationale for the concentration of high rebates that defines a negative skew.³
- **It is Contradicted by the Best Available Proxy Data:** The highly competitive generic drug market provides the only available empirical window into the behavior of a distribution of pharmaceutical discounts. Data from the FDA and ASPE overwhelmingly show that as competition increases, discounts become extremely high, with many products seeing price reductions of 80-95%.³¹ This creates a distribution with its mass heavily concentrated at the highest end of the scale—a clear and unambiguous negative skew.
- **It Models the Wrong Variable:** The assumption fails to distinguish between "gross rebates" (manufacturer-to-PBM) and "effective rebates" (the net value realized by payers). The business models of PBMs, particularly fees linked to high list prices, systematically erode the value of rebates. This process shifts the entire distribution leftward, making the *effective* rebate distribution—the one that actually determines costs and federal spending—even more negatively skewed than the gross distribution.⁷

Section 8. Effects of Vertical Integration of PBMs with Pharmaceutical Manufacturers, Pharmacies, and other Supply Chain Vendors

The Captive Channel: How PBM-Owned Specialty Pharmacies Drive Profit and Market Control

The rise of specialty pharmaceuticals—high-cost, complex medications used to treat chronic conditions like cancer, multiple sclerosis, and rheumatoid arthritis—has reshaped the economics of the drug industry.²¹ This lucrative market segment, which now accounts for over half of all prescription drug spending, has become the financial engine of the vertically integrated PBM model.¹³ By establishing and controlling their own "captive" specialty pharmacies, the "Big Three" PBMs have secured a dominant position in this critical channel. This section will analyze how PBMs leverage their ownership of specialty pharmacies like Accredo, CVS Specialty, and Optum Specialty to control the distribution of the most expensive drugs, employ tactics to steer patients into their captive network, and extract billions of dollars in profits through opaque markups and reimbursement schemes that disadvantage competitors and inflate costs for the entire healthcare system.

Dominance by Design: Market Share and Strategic Importance

The specialty pharmacy market is not a competitive landscape; it is an oligopoly controlled by the PBMs. In 2024, an estimated two-thirds of all prescription revenues from pharmacy-dispensed specialty drugs were generated by the three largest specialty pharmacies, each of which is owned by one of the "Big Three" PBM conglomerates.²² This market concentration is not accidental but is the result of deliberate strategies employed by both payers and pharmaceutical manufacturers to create "limited" or "narrow" distribution networks for these sensitive and expensive drugs.¹⁹

When a new specialty drug comes to market, its manufacturer often restricts its distribution to a small number of authorized specialty pharmacies. These networks almost invariably include Accredo (owned by Cigna/Express Scripts), CVS Specialty, and Optum Specialty Pharmacy.¹⁹ Payers, which are frequently the PBMs' own affiliated health plans, reinforce this concentration by designating their own specialty pharmacies as the "preferred"

or sometimes exclusive providers for their members. This creates a powerful, self-reinforcing cycle: PBMs control the formularies and pharmacy networks for millions of patients, which gives them leverage to demand inclusion in manufacturers' limited distribution networks. Once included, they can then steer their members to their own pharmacies, further solidifying their market share and making it nearly impossible for independent specialty pharmacies to compete.¹⁰ This control over the most profitable sector of the pharmaceutical market is a core component of the PBMs' business strategy, with specialty drug dispensing accounting for approximately one-third of their total gross profits in 2024.²²

The Mechanics of Patient Steering

"Patient steering" is the term for a set of practices PBMs employ to channel prescriptions to their wholly owned retail, mail-order, or specialty pharmacies, often irrespective of patient or provider preference.¹⁶ This is not merely a suggestion or an incentive; it is often a mandate enforced through the design of the pharmacy benefit itself. PBMs accomplish this through several tactics:

- **Restrictive Network Design:** PBMs can simply leave independent pharmacies out of their specialty networks or place them in "non-preferred" tiers with prohibitively high patient cost-sharing.²³
- **Mandatory Mail-Order/Specialty Use:** PBMs often require patients to use their affiliated mail-order or specialty pharmacies to obtain in-network coverage for their medications. Patients who wish to use their local, independent pharmacy may be forced to pay the full cash price or a much higher out-of-pocket share.¹⁰
- **Non-Consensual Prescription Transfers:** Pharmacist associations report that PBMs frequently transfer patient prescriptions to their own pharmacies without the knowledge or consent of the patient or their original pharmacy.¹⁶

The impact of these steering practices is quantifiable and significant. A rigorous cross-sectional study of 2021 Medicare Part D claims data provided stark evidence of this behavior. The analysis compared where a PBM's own health plan members filled their prescriptions versus where members of other health plans filled prescriptions at that same PBM's pharmacies. The results showed a dramatic and systematic preference for their own pharmacies. For specialty drugs, the study estimated that steering practices resulted in a 19.8 percentage-point greater share of claims being filled at an insurer-PBM's owned pharmacy

than would be expected in a neutral, competitive market.²³ This demonstrates that network access is not equal and that PBMs use their integrated position to systematically direct lucrative specialty prescriptions to themselves.

Table 2: Evidence of Patient Steering to Insurer-PBM-Owned Pharmacies (Medicare Part D, 2021)			
Insurer-PBM Firm	Median Share of Own Insurer Claims Filled at Own Pharmacies (%)	Median Share of Other Insurer Claims Filled at Own Pharmacies (%)	Pair-wise Difference (Percentage Points)
CVS	24.7%	12.2%	12.8
UnitedHealth Group	19.7%	2.1%	9.4
Cigna	25.4%	1.7%	23.2
Humana	16.6%	0.1%	16.6
All Firms (Mean)	-	-	19.8

Adapted from study data in sources²³ and²⁴ The pair-wise difference represents the estimated steering effect for specialty drugs.

The Economics of Self-Dealing: Inflated Markups and Reimbursement Disparities

Patient steering is not simply about market share; it is a mechanism that enables enormous profit extraction. By foreclosing the market to competitors, PBMs can dictate pricing and reimbursement terms in a non-competitive environment, leading to inflated costs for plan sponsors and patients. Federal investigations have begun to uncover the scale of this self-dealing. A recent report from the Federal Trade Commission (FTC) stated bluntly that vertically integrated PBMs have both the ability and the incentive to prefer their own affiliated businesses, creating conflicts of interest that disadvantage rivals and increase drug costs.¹⁸

An FTC interim staff report published in January 2025 provided shocking quantitative evidence of this practice. The report found that the "Big Three" PBMs impose staggering markups on specialty generic drugs dispensed at their captive pharmacies. These markups

often reached hundreds or even thousands of percent above the drug's estimated acquisition cost.²⁵ In one documented example, PBMs were charging plan sponsors \$3,930 for a drug that cost only \$177 to acquire—a markup of over 2,100%.²⁶ The FTC calculated that these practices allowed the "Big Three" PBMs and their affiliated specialty pharmacies to generate more than \$7.3 billion in revenue in excess of the drugs' estimated acquisition costs between 2017 and 2022.²⁵

This practice is further compounded by discriminatory reimbursement. PBMs, acting as the administrator for health plans, determine how much to pay pharmacies for dispensing a drug. Reports from state auditors and pharmacist associations have consistently found that PBMs reimburse their own affiliated pharmacies at significantly higher rates than they reimburse unaffiliated independent pharmacies for the exact same drug.³ An audit in Ohio, for instance, found a substantial disparity in payments between PBM-owned and independent pharmacies.²⁶ This two-pronged approach—inflating the price charged to the health plan while simultaneously squeezing the reimbursement paid to independent competitors—maximizes the conglomerate's profit and systematically drives independent pharmacies out of the market.

Table 3: Summary of FTC Findings on Specialty Generic Drug Markups (2017-2022)	
Key Finding Metric	Description / Data Point
Total Dispensing Revenue in Excess of Acquisition Cost	Over \$7.3 billion
Compound Annual Growth Rate of Excess Revenue (2017-2021)	42%
Share of Top 10 Drugs in Total Excess Revenue	85% (\$6.2 billion)
Examples of Extreme Markups	Markups of hundreds and thousands of percent on drugs for cancer, HIV, and other serious conditions.

Data compiled from FTC interim staff report, sources ²⁵ and ²⁶.

Case Studies: Accredo, CVS Specialty, and Optum Specialty Pharmacy

The three dominant specialty pharmacies operate as integral components of their parent conglomerates, each leveraging the integrated structure in a similar fashion.

- **Accredo (Cigna/Express Scripts):** As a wholly owned subsidiary of Express Scripts, Accredo is one of the largest specialty pharmacies in the nation.²⁷ It promotes its clinical expertise through 15 condition-specific "Therapeutic Resource Centers®" (TRCs), which provide patients with specialized support from pharmacists, nurses, and social workers.²⁹ While these services offer real value to patients managing complex diseases, they also function as a powerful tool for patient retention, deeply embedding the patient within the Cigna/Express Scripts ecosystem and making it more difficult for them to switch to an outside pharmacy. Despite its marketing of high-touch care, Accredo has been the subject of class-action lawsuits and extensive criticism for significant delays in medication delivery and poor patient service, which can have life-threatening consequences for patients dependent on these therapies.²⁸
- **CVS Specialty (CVS Health):** CVS Specialty is perhaps the most deeply integrated of the three. It operates in concert with the CVS Caremark PBM, the Aetna insurance company, and the nation's largest retail pharmacy chain, CVS Pharmacy.²¹ This seamless integration allows the conglomerate to manage every aspect of a specialty patient's journey, from the insurance coverage decision made by Aetna, to the benefit management by Caremark, to the final dispensing at a CVS Specialty or retail location. This closed loop maximizes data collection and control, reinforcing patient capture and ensuring that revenue from these high-cost drugs remains within the CVS Health enterprise.
- **Optum Specialty Pharmacy (UnitedHealth Group):** Housed within Optum, the health services arm of UnitedHealth Group (UHG), Optum Specialty Pharmacy works hand-in-glove with the Optum Rx PBM and the nation's largest insurer, UnitedHealthcare. This triad creates a formidable, closed system for managing specialty drug patients. A prescription for a UnitedHealthcare member is managed by Optum Rx, which then directs the prescription to be filled at Optum Specialty Pharmacy. This structure ensures that the billions of dollars spent on specialty drugs by UnitedHealthcare's members are funneled directly back into another division of the same parent company, UHG, amplified by the significant markups documented by the FTC.

The New Frontier: PBMs as Virtual Manufacturers

In a bold and strategic evolution of their business model, the "Big Three" PBMs are moving further upstream in the pharmaceutical supply chain by creating a new class of subsidiary: the "virtual manufacturer" or private-label distributor. Companies like CVS Health's Cordavis, Cigna's Quallent, and UnitedHealth Group's Nuvaia do not manufacture drugs themselves. Instead, they partner with pharmaceutical companies to co-brand, co-produce, or exclusively distribute medications, particularly high-value biosimilars. This maneuver represents a sophisticated new frontier for profit generation, allowing PBMs to capture a direct share of drug sales revenue, exert greater control over market competition, and strategically insulate their profits from the growing threat of rebate reform.

Beyond the Rebate: The Strategic Rationale for a New Model

The creation of these virtual manufacturer subsidiaries is a direct response to the intense and mounting pressure on the traditional PBM business model. For decades, PBMs have derived a significant portion of their profits from the opaque system of manufacturer rebates.² However, this model is now under sustained attack from federal and state legislators, regulators, and payers who are demanding greater transparency and mandatory pass-through of these rebates to plan sponsors and patients.²

Faced with the existential threat of reform that could dismantle their primary profit center, PBMs have proactively developed a new one. By creating private-label subsidiaries, they are fundamentally shifting their revenue source. Instead of collecting a percentage of a hidden rebate tied to a drug's list price, they are now positioned to capture a direct portion of the drug's sales revenue itself.¹⁹ This strategy offers several advantages:

- **Profit Insulation:** It creates a new, more direct revenue stream that is less vulnerable to legislation targeting rebates.
- **Enhanced Control:** It allows the PBM to act not just as a negotiator but as a commercialization partner, giving it unprecedented influence over which products succeed in the market.
- **Obfuscation and Tax Strategy:** The structure of these new entities, with some being based overseas (e.g., Cordavis and Nuvaia in Ireland), may provide tax advantages and create additional layers of complexity that make it difficult for regulators and clients to

track the flow of money.¹⁹

Disrupting the Supply Chain: The Virtual Manufacturer Playbook

The operational model of these subsidiaries is innovative and disruptive. They function by inserting themselves as a new, powerful intermediary between the actual drug manufacturer and the rest of the supply chain. Their playbook typically involves the following steps:

1. **Strategic Partnership:** The PBM subsidiary identifies a key drug, often a biosimilar of a major blockbuster biologic like Humira or Stelara, and forms a partnership with the manufacturer.²⁰
2. **Co-Branding and Distribution:** The subsidiary agrees to market the drug under its own private label (e.g., "Cordavis Hyrimoz" or "Wezlana for Nuvaaila") and often secures exclusive or co-exclusive distribution rights for the U.S. market.²⁰
3. **Supply Chain Management:** The PBM subsidiary takes on functions traditionally managed by the manufacturer, such as demand forecasting, quality control oversight, logistics management, and ensuring a stable supply.³⁴
4. **Guaranteed Market Access:** The most critical step is leveraging the power of the affiliated PBM. The PBM places its own private-label product in a preferential position on its national formularies, guaranteeing market access and directing the prescription volume of millions of patients to its partnered product.²⁰

This model effectively allows the PBM conglomerate to hand-pick the winners in the nascent biosimilar market, undermining the competitive dynamics that were supposed to drive down prices.

Dual Pricing and Market Capture

A key tactic employed by these new entities, particularly in the biosimilar space, is a sophisticated dual-pricing strategy. When launching a new private-label biosimilar, they often introduce it to the market with two distinct price points:

- **A High-WAC (Wholesale Acquisition Cost) Version:** This version has a high list price, which allows the PBM to negotiate a large rebate from the manufacturing partner. This product is attractive to health plan clients whose financial models rely on receiving

substantial rebates to offset high premiums.²⁰

- **A Low-WAC Version:** This version is launched with a dramatically lower list price (e.g., 80% less than the brand) and carries little to no rebate. This product can be marketed as a low-cost option, appealing to patients with high deductibles or coinsurance, and generating positive publicity.²⁰

This dual-pricing approach is a masterful strategy for market capture. It allows the PBM to neutralize the threat that low-cost biosimilars pose to its high-rebate business model. Instead of allowing a price war to erupt that would benefit all payers, the PBM controls the transition on its own terms. It can satisfy all segments of its client base while ensuring that its own co-branded product becomes the dominant biosimilar on the market. This effectively locks out competing biosimilar manufacturers who are not chosen as the PBM's partner, stifling the very competition that biosimilars were intended to create.²⁰

Corporate Profiles: Cordavis, Quallent, and Nuvaia

The simultaneous emergence of these subsidiaries across all three major PBMs underscores that this is a coordinated, industry-wide strategic pivot.

- **Cordavis (CVS Health):** Launched in August 2023 and based in Dublin, Ireland, Cordavis was created to work directly with manufacturers to commercialize biosimilars.³³ Its flagship product is a co-branded version of Sandoz's Hyrimoz, a biosimilar to the world's best-selling drug, Humira. Cordavis launched its version at a list price more than 80% below Humira's, a move that CVS Health framed as a way to reduce drug spend and ensure access.³³ However, by leveraging CVS Caremark's formulary power, the move also ensures that its partnered product gains a significant competitive advantage over other Humira biosimilars.³⁵
- **Quallent (Cigna/Evernorth):** Established in 2021, Quallent operates as a private-label pharmaceutical distributor that sources select drugs from FDA-approved manufacturers.³⁴ Its stated mission is to bring "quality consistency and stability" to the supply chain by overseeing manufacturing processes and managing logistics.³⁴ This gives Cigna's Evernorth division deeper control over the supply chain and allows it to offer "dedicated inventory" to pharmacies, a powerful lever in a market often plagued by shortages.

- **Nuvaila (UnitedHealth Group/Optum):** Nuvaila describes itself as a "pharmaceutical commercialization business" that creates an "express lane for products" by partnering with manufacturers.³⁸ Also based in Ireland, Nuvaila made a major market entrance by becoming the sole U.S. distributor for Wezlana, Amgen's biosimilar to Stelara.²⁰ In a clear demonstration of the integrated model's power, Optum Rx immediately added Wezlana to its commercial formularies upon its launch. This exclusive partnership effectively guarantees Amgen a significant share of the Stelara biosimilar market via Optum's channels, disadvantaging any other manufacturer of a Stelara biosimilar from the outset.²⁰

This strategic pivot into virtual manufacturing represents a form of "soft" vertical integration. Without the capital expense of building factories, PBMs are integrating "upward" into the drug commercialization process. They leverage their immense downstream power—control over the formularies that determine market access for virtually all drugs—to guarantee the success of their upstream partners. This dynamic fundamentally distorts the competitive landscape, transforming the PBM from a supposed negotiator for lower prices into an entity that actively picks winners and losers to maximize its own profit.

Evidence of Harm: Raising Rivals' Costs and Foreclosure

Recent empirical research has moved the discussion of anticompetitive harm from theory to documented fact. The strategies of patient steering and exclusive biosimilar partnerships are clear, real-world examples of customer and input foreclosure. Beyond these practices, economic studies have quantified the impact of PBM-insurer integration on rival firms.

A working paper from the University of Chicago provided a detailed analysis of the Medicare Part D market and found compelling evidence of integrated PBMs raising rivals' costs.³⁹ The study estimated that, on average, standalone PBMs passed through 85% of the rebates they negotiated to their insurer clients. In contrast, vertically integrated PBMs passed through only 65% of rebates to their unaffiliated insurer clients, while presumably passing through 100% to their own insurance arm.³⁹ This disparity demonstrates that integrated PBMs are systematically disadvantaging their insurance market rivals by withholding a larger portion of the negotiated savings.

Further evidence comes from a study examining the 2015 acquisition of Catamaran, the last major standalone PBM, by UnitedHealth Group.⁴⁵ The acquisition forced former clients

of Catamaran to switch to using a PBM owned by a rival insurer. The study found that following this merger, the non-vertically-integrated insurers experienced premium increases of 36% relative to their vertically-integrated counterparts, a finding consistent with the theory of input foreclosure.⁴⁵ The removal of a viable independent PBM option left these insurers vulnerable to the anticompetitive terms of the remaining integrated PBMs.

The Net Impact on Drug Prices and Spending

Ultimately, the most important question is whether vertical integration, on balance, lowers or raises costs for the healthcare system. The evidence strongly suggests that any potential efficiencies are being overwhelmed by anticompetitive effects and profit-maximizing behaviors that lead to higher net costs.

The Congressional Budget Office (CBO) offers a nuanced but critical assessment. It concludes that while PBM-insurer integration might lower drug prices for the members of that specific, integrated plan, it also tends to increase drug costs and premiums for other, rival insurers that use the same PBM.¹⁵ Furthermore, the CBO states that there is no guarantee that any savings achieved by the integrated plan are actually passed on to its enrollees as lower premiums.¹⁵

The CBO's findings on PBM-pharmacy integration are even more troubling. It reports that the evidence is "inconclusive" but points to a 2023 Medicare Payment Advisory Commission (MedPAC) study that found that, in a majority of cases, the highest net prices for drugs were paid by vertically integrated plans to their own vertically integrated pharmacies.¹⁵ This directly contradicts the efficiency argument and suggests that the integrated structure is being used to shift profits to the pharmacy division through inflated internal transfer prices, which are then passed on to the plan sponsor (and, ultimately, to employers and taxpayers) as higher "drug costs."

This conclusion is powerfully reinforced by the FTC's findings of billions of dollars in excess revenue generated through extreme markups at PBM-owned specialty pharmacies.²⁵ This is not a theoretical harm; it is a documented, multi-billion-dollar inflation of drug costs occurring within the captive channels of the integrated PBMs. The very rebate system that PBMs manage also contributes to higher prices. Because rebates are typically calculated as a percentage of a drug's list price, PBMs have a financial incentive to favor higher-priced drugs on their formularies, as a 30% rebate on a \$1,000 drug is more profitable than a 20% rebate

on a \$300 drug, even if the latter has a lower net cost.² Vertical integration solidifies the PBM's power to enforce these formulary decisions, perpetuating the cycle of high list prices and high rebates.

The integrated model also creates a "waterbed effect" that makes it exceedingly difficult for payers and regulators to assess true costs. An integrated PBM can showcase savings in one area—for example, by offering a competitive premium to its own health plan members by passing through a full rebate—while simultaneously raising costs elsewhere. These hidden costs can manifest as poorer rebate terms for rival insurers, or as massive, non-transparent markups at its specialty pharmacy that are billed back to all plan sponsors using its services.²⁵ This ability to shift profits and costs across different business units within the conglomerate allows PBMs to claim they are "saving money" while the total cost to the system continues to rise.

The Government Response: A Consensus of Concern

Across multiple branches and levels of government, a striking consensus has emerged: the vertically integrated PBM model is contributing to higher drug costs and harming competition.

- **Federal Trade Commission (FTC):** The FTC has taken the lead in investigating the PBM industry. In 2022, the agency launched a formal inquiry under its Section 6(b) authority, compelling the six largest PBMs to provide extensive data on their business practices.⁸ The initial findings, released in a series of interim reports, have been scathing. A July 2024 report described PBMs as "powerful middlemen inflating drug costs and squeezing Main Street pharmacies," highlighting how market concentration and vertical integration enable them to profit at the expense of patients and independent pharmacists.¹⁸ A subsequent report in January 2025 detailed billions of dollars in excessive markups on specialty generic drugs at PBM-affiliated pharmacies.²⁵
- **Congressional Investigations:** The U.S. Congress has conducted its own extensive investigations. A 2024 report from the House Committee on Oversight and Accountability concluded that the "Big Three" PBMs "inflate prescription drug costs and interfere with patient care for their own financial benefit".¹³ The committee found that PBMs "embrace anticompetitive behavior," using their power to steer patients to their own pharmacies and force manufacturers to pay exorbitant rebates.²⁶
- **State-Level Audits and Reports:** Frustrated by rising costs in their Medicaid and state

employee health programs, numerous states have conducted audits that exposed the financial consequences of opaque PBM practices. An Ohio state audit, for example, found that PBMs had charged the state's Medicaid managed care program \$224.8 million in "spread pricing"—the difference between what the PBM charged the state and what it paid the pharmacy—in a single year.²⁶ Similar patterns of overbilling have been uncovered in states like Illinois and Kentucky, revealing hundreds of millions of dollars in excess costs to taxpayers.²⁶

The Legal Battlefield: Antitrust in Action

The findings from these investigations are now translating into significant legal challenges that target the core of the PBMs' integrated practices.

- **FTC Lawsuit on Insulin Pricing:** In a landmark move in September 2024, the FTC filed an administrative complaint against the "Big Three" PBMs and their affiliated group purchasing organizations (GPOs).⁴⁸ The lawsuit alleges that the PBMs abused their market power to create a "broken rebate system that inflated insulin drug prices, boosting PBM profits at the expense of vulnerable patients."²⁶ The FTC charges that the PBMs' financial incentives are tied to high list prices, leading them to systemically exclude lower-cost insulins and biosimilars from their formularies in favor of high-priced, high-rebate products, thereby harming patients and stifling competition.⁴⁹
- **Other Lawsuits and Settlements:** The "Big Three" have faced a barrage of other legal actions from state attorneys general, private plaintiffs, and other government bodies.

These include:

- A \$20 million settlement by OptumRx in 2024 for improperly filling opioid prescriptions.²⁶
- A \$15 million settlement by OptumRx with the state of Ohio for overbilling its Bureau of Workers' Compensation.²⁶
- A Tennessee investigation that found Express Scripts systematically violated state laws by failing to properly reimburse pharmacies and paying its own specialty pharmacy higher fees than its competitors.²⁶
- Multiple class-action lawsuits alleging that PBMs have engaged in horizontal price-fixing conspiracies to suppress reimbursement rates to independent

pharmacies.⁵⁰

This pattern of litigation demonstrates that the anticompetitive behaviors identified by regulators are not isolated incidents but rather systemic practices that are now being aggressively challenged in court. In a notable defensive maneuver, the PBMs have responded to the FTC's lawsuit by suing the agency back, claiming its case is unconstitutional—a legal strategy focused on procedural deflection rather than a substantive refutation of the charges.³²

Section 9. Effects of List Prices on Patient Co-insurance

Increasing Cost-Sharing through High List Prices

By increasing the list prices of medications, patient cost-sharing through co-insurance increases, decreasing immediate pharmacy spend for plan sponsors. However, we argue here that resulting patient non-compliance with medication adherence results in medical benefit spend that more than offsets pharmacy spend savings. The net results is increased healthcare spend for plan sponsors.

Cost-Sharing as a Tool to Mitigate "Moral Hazard"

In addition to directly decreasing plan spend, the implementation of patient cost-sharing mechanisms—such as copayments, coinsurance, and deductibles—is rooted in a foundational economic theory aimed at controlling health care expenditures. From the perspective of a plan sponsor, a primary objective is to mitigate the "moral hazard" inherent in insurance coverage.¹ This principle suggests that when individuals are insulated from the full cost of a service, they may consume more of it than they would otherwise, including care that may be of marginal value. In the context of pharmaceuticals, this could manifest as over-utilization of medications or a preference for higher-cost brand-name drugs when effective, lower-cost alternatives are available.³

The theory posits that by requiring patients to have "skin in the game" through out-of-pocket payments, they are incentivized to become more discerning and cost-conscious consumers of health care.⁴ This financial exposure is intended to curb demand for costly or non-essential therapies and encourage the selection of more cost-effective options, thereby reducing the plan sponsor's overall pharmacy expenditures. This strategy has become particularly prevalent as spending on drug therapies has grown at a faster rate than spending on hospital and physician services, which constitute a larger portion of total health care costs.¹

Quantitative Evidence: The Direct Effect of Cost-Sharing on Drug

Utilization and Pharmacy Spending

A substantial body of evidence confirms that the primary, intended effect of increasing patient cost-sharing is achieved: it reduces the consumption of prescription drugs. This direct impact on utilization is the mechanism through which plan sponsors realize initial savings on their pharmacy benefit spend.

Multiple systematic reviews of the academic literature have consistently validated this relationship. A comprehensive review encompassing 160 separate studies found that in 85% of cases, an increase in the patient's share of medication costs was significantly associated with a decrease in medication adherence.¹ A more recent systematic review of 79 studies published between 2010 and 2020 yielded similar conclusions, finding that higher patient cost-sharing was associated with worse medication adherence in 84% of studies and with decreased medication initiation in 67% of studies.⁶

The "gold standard" of evidence in this area comes from the landmark RAND Health Insurance Experiment (HIE), a large-scale, randomized controlled trial conducted from 1974 to 1982. The HIE's rigorous design provides strong causal evidence of the effect of cost-sharing on utilization. The experiment's findings showed that for every 10% increase in patient cost-sharing, prescription drug spending decreased by 2% to 6%, with the magnitude of the effect varying by drug class and patient condition.⁸ In the most extreme arm of the study, participants required to pay 95% of their health care costs (up to an out-of-pocket maximum) reduced their overall spending by approximately 30% compared to participants who received free care.¹⁰

This effect has been quantified for specific drug classes and benefit designs. One study found that when insurers doubled patient copayments, the number of days' supply filled by patients decreased by 45% for nonsteroidal anti-inflammatory drugs (NSAIDs), 44% for antihistamines, and 34% for antihyperlipidemics (statins).¹¹ From a narrow, pharmacy-centric accounting perspective, these reductions in use translate directly into plan sponsor savings. For instance, a study by Joyce et al. in 2002 found that doubling a plan's copayment from \$5 to \$10 resulted in a decrease in per-member total annual drug costs from \$725 to \$563.¹¹

The Flaw in the "Rational Consumer" Assumption

The economic theory justifying cost-sharing is built upon a critical assumption: that patients, when faced with higher out-of-pocket costs, will behave as rational consumers. This assumes they can accurately differentiate between "high-value" care (medically necessary treatments) and "low-value" care (discretionary or less effective treatments) and will selectively curtail their use of only the latter.¹ If this assumption held true, cost-sharing would be an effective tool for eliminating waste without negatively impacting health. However, a wealth of evidence demonstrates this assumption is fundamentally flawed.

The RAND HIE provided the first major challenge to this theory. Its findings revealed that patients facing higher cost-sharing reduced their use of services deemed "clinically appropriate" by the same amount as they reduced services deemed "clinically inappropriate."¹⁰ Patients did not selectively trim waste; they reduced care across the board. Decades of subsequent research have reinforced this conclusion. Higher levels of cost-sharing are consistently associated with lower rates of treatment and worse adherence for essential, life-sustaining medications for chronic conditions such as congestive heart failure, diabetes, and schizophrenia.⁸ This indicates that cost-sharing is not a precision tool that encourages prudent health care consumption. Instead, it acts as a blunt instrument that creates a financially burdened consumer who is forced to reduce both necessary and unnecessary care, often indiscriminately. This critical distinction explains why the initial savings on the pharmacy budget are often erased by subsequent costs on the medical side, a phenomenon known as the medical cost offset.

The Medical Cost Offset: A Quantitative Reassessment of Total Plan Savings

Defining the Medical Cost Offset

While increasing patient cost-sharing reliably reduces pharmacy expenditures, this represents only one side of the ledger for a plan sponsor. The total financial impact must account for the "medical cost offset," a well-documented phenomenon where initial savings in drug spending are partially or fully negated—and in some cases, reversed—by subsequent increases in spending on medical services.⁹ These downstream costs, which include

emergency room visits, hospitalizations, and physician services, arise directly from the consequences of cost-related medication non-adherence, leading to poorer health outcomes and the need for more intensive and expensive medical interventions.¹³

The Causal Chain: From Cost-Sharing to Increased Medical Spending

The link between higher patient payments and higher total plan costs can be understood as a clear, evidence-based causal chain.

1. **Higher Cost-Sharing Reduces Adherence:** As established previously, this link is robust and widely confirmed. Systematic reviews consistently show that in the vast majority of cases (up to 85% of studies), increasing the patient's financial burden leads to a significant decrease in medication adherence.¹
2. **Reduced Adherence Leads to Worse Health Outcomes:** The clinical consequence of non-adherence is a deterioration in health. The majority of studies that investigate this relationship find that increased adherence is associated with statistically significant improvements in health outcomes.¹ For patients with chronic conditions, non-adherence can lead to a cascade of negative effects, including disease progression, prolonged illness, and preventable complications.¹⁴
3. **Worse Health Outcomes Drive Higher Medical Utilization:** This final step in the chain directly impacts the plan sponsor's medical budget. When chronic conditions are poorly managed due to medication non-adherence, patients require more frequent and intensive medical care. A 2022 systematic review found that in 67% of studies examining the link, higher patient cost-sharing for drugs was associated with a significant increase in inpatient hospital utilization.⁶ A landmark study conducted in British Columbia provides a stark quantitative example. When the public drug plan introduced a modest copayment policy for inhaled medications for patients with chronic respiratory conditions, drug use fell by 6% to 13%. This reduction was associated with a 3% increase in physician visits and a 13% increase in emergency hospital admissions (though the latter was not statistically significant). When the plan later implemented a more stringent policy with income-based deductibles and coinsurance, it was associated with a 7% increase in physician visits and a statistically significant 29% increase in emergency hospital admissions.¹⁵

Quantifying the Net Financial Impact on Plan Sponsors

The ultimate question for a plan sponsor is whether the savings on the pharmacy side outweigh the increased costs on the medical side. The evidence strongly suggests they do not, and that increasing patient cost-sharing often results in a net financial loss for the plan.

The U.S. Congressional Budget Office (CBO), after a thorough review of the available evidence, formally revised its scoring methodology to account for this effect. The CBO now estimates that for every **1% increase in the number of prescriptions filled by Medicare beneficiaries, the program's spending on medical services falls by approximately 0.2%**.¹³ This estimate from a key government fiscal scorekeeper provides a high-level validation of the inverse relationship between drug utilization and medical costs.

Research from the National Bureau of Economic Research (NBER) offers an even more striking quantification of this trade-off. An analysis of Medicare beneficiaries found that, on average, a **\$1 increase in prescription drug spending was associated with a \$2.06 reduction in Medicare spending**, primarily from reduced hospitalizations covered under Part A.¹⁶ This finding suggests that for every dollar "saved" by reducing drug use, the plan sponsor may be spending more than two dollars on subsequent medical care.

The British Columbia study provides a real-world accounting of this net effect. Despite reducing drug utilization, the initial copay policy **increased net health plan spending by C\$1.98 million per year**. The subsequent, more restrictive deductible and coinsurance policy **increased net health plan spending by C\$5.76 million per year**.¹⁵ This demonstrates that even after accounting for the reduction in pharmacy claims, the plan paid more in total.

This body of evidence is summarized in a 2022 systematic review which concluded that higher cost-sharing has an **overall neutral to negative impact on total costs** for the plan sponsor. Perhaps most tellingly, studies that evaluated the *elimination* of patient copayments found that this action resulted in either a decrease or no change in total plan costs, directly contradicting the foundational theory that cost-sharing is a necessary tool for cost containment.³

Table 1: Summary of Quantitative Effects of Increased Patient Cost-Sharing on Utilization and Costs

Metric	Quantitative Impact of Increased Cost-Sharing	Source(s)
Medication Adherence	85% of studies show a significant decrease.	⁷
Medication Initiation	67% of studies show a significant decrease.	⁹
Prescription Drug Spending	Decreases by 2% to 6% for every 10% increase in cost-sharing.	⁸
Physician Visits	Increased by 3% to 7% in one major study.	¹⁵
Hospital Admissions (ER)	Increased by up to 29% in one major study.	¹⁵
Total Plan Sponsor Costs	Neutral to Increased. Net plan spending increased by C1.98M to C5.76M annually in one study.	⁹
Medical Cost Offset Ratio	\$1 increase in drug spend leads to a \$2.06 decrease in medical spend.	¹⁶
CBO Offset Estimate	1% increase in prescriptions filled leads to a 0.2% decrease in medical spend.	¹³

High-Deductible Health Plans (HDHPs): A Blunt Instrument with Mixed Results

High-Deductible Health Plans (HDHPs) represent a more extreme form of cost-sharing, requiring patients to pay the full, negotiated price for all services, including prescriptions, until a substantial deductible is met.²⁶ The evidence on their effectiveness in saving plan sponsors money is notably mixed.

One NBER study of a large employer that switched to an HDHP found that the move reduced overall health care spending by 12% to 14% annually. However, these savings were achieved almost entirely through a blunt reduction in the quantity of services demanded, affecting both necessary and unnecessary care alike.²⁶ This indiscriminate reduction in care is a significant concern, especially for populations with chronic conditions. Indeed, another

study found that switching to an HDHP was associated with a 5 percentage point drop in medication adherence for cardiovascular risk factors.²⁹

Counterintuitively, some evidence suggests HDHPs may not save money at all. One study found that HDHP enrollment was associated with an *increase* in prescription medication use and no significant change in overall outpatient expenditures.³⁰ The authors noted that the impact of HDHPs is complex, with some patient subgroups (such as the chronically ill) potentially increasing their utilization to manage their conditions despite the higher costs. This highlights the risk that for certain populations, HDHPs can fail to contain costs while simultaneously increasing financial burdens and reducing adherence to essential therapies.

Table 2: Comparative Analysis of Cost-Sharing Mechanisms

Feature	Copayment (Fixed \$)	Coinsurance (% of Price)	High-Deductible (Full Price)
Patient Cost Predictability	High	Low (Tied to list price)	Low (Full exposure until deductible met)
Plan Exposure to Price Inflation	High (Plan absorbs increases)	Low (Patient shares increases)	Low (Patient absorbs increases below deductible)
Impact on Adherence	Negative, but less severe	Highly negative, especially for high-cost drugs	Highly negative, especially for chronic medications
Risk of Medical Cost Offset	Moderate	High	Very High
Net Savings for Plan Sponsor	Unlikely; often negative due to offset	Unlikely; often negative due to offset	Mixed evidence; risk of increased costs for chronically ill populations
Source(s)	²⁰	²²	²⁶

How Benefit Design Creates a Vicious Cycle of Price Inflation

The choice of benefit design, particularly the widespread adoption of coinsurance, does not merely react to high drug prices but actively contributes to their inflation. This creates a perverse set of incentives that benefits pharmaceutical benefit managers (PBMs) at the expense of both patients and plan sponsors. The mechanism works as follows: PBMs negotiate rebates from drug manufacturers, which are typically calculated as a percentage of a drug's wholesale acquisition cost, or "list price." In return for a larger rebate, the PBM places

the drug on a preferred formulary tier.³¹

This system incentivizes PBMs to favor drugs with high list prices and high rebates over drugs with lower list prices and smaller rebates, even if the latter drug has a lower net cost to the plan sponsor after the rebate is factored in.³³ When a health plan uses a coinsurance model, the patient's out-of-pocket cost is calculated based on the inflated list price, *before* the rebate is applied.²³ The plan sponsor receives the rebate weeks or months later, but the patient pays a higher cost at the pharmacy counter. These inflated patient payments effectively subsidize the premiums for all plan members.²³

This dynamic creates a vicious cycle. Manufacturers have an incentive to set high list prices to be able to offer the large rebates PBMs demand. PBMs have an incentive to populate formularies with these high-rebate drugs. Plan sponsors who then use coinsurance pass a significant portion of that inflated list price directly onto their sickest members—those who need the medications most. The sponsor may see a lower net drug cost on its financial statements after rebates are accounted for, but this "saving" is achieved by increasing the financial burden on the very members most likely to become non-adherent. This non-adherence then triggers the medical cost offset, ultimately increasing the sponsor's total health care spending. In this way, the benefit design itself fuels the very problem of high costs it is intended to solve.

The Human and Economic Cost of Non-Adherence: Mortality and Long-Term Liabilities

The most sobering evidence against the cost-saving claims of aggressive cost-sharing policies is the direct, quantitative link between increased patient out-of-pocket costs and higher rates of mortality. This demonstrates that the consequences of cost-related non-adherence are not limited to manageable increases in medical utilization but extend to the most severe and irreversible of outcomes.

A rigorous NBER working paper exploited a feature of the Medicare Part D benefit design where beneficiaries' out-of-pocket costs for drugs could increase abruptly during the year upon entering the "donut hole." The researchers found a sharp and statistically significant increase in mortality corresponding with this price shock. The study's central

quantitative finding was that for every **\$100 per month decrease in a beneficiary's drug budget** (which is equivalent to a \$100 per month increase in their out-of-pocket costs), **mortality increased by 13.9%.**⁴²

This effect was not distributed randomly. The analysis revealed that high-risk patients—for example, those with cardiovascular conditions who were most likely to suffer a heart attack—were the most likely to cut back on the very drugs, such as statins, that were most critical to their survival.⁴² The researchers calculated that these cost-sharing policies cause patients to forgo opportunities to preserve their health at a very low cost, estimating the price of the resulting mortality at just **\$11,321 per life-year.**⁴²

Cost-Sharing as a Creator of Hidden, Long-Tail Financial Risk for Sponsors

The mortality data reveal a profound, often unmeasured, long-tail financial risk for plan sponsors created by cost-sharing policies. While a deceased member no longer generates claims, the period of health decline leading up to that outcome, which is driven by medication non-adherence, is often characterized by intensive and inefficient medical spending. For an employer, this represents not only a human tragedy but also a period of lost productivity and high health care costs. For a public sponsor like Medicare, it represents a direct failure of the program's core mission to maintain the health of its beneficiaries.

From a purely financial standpoint, a plan sponsor's highest costs are frequently concentrated in the period leading up to a major adverse health event or death. The mortality finding is the most extreme manifestation of the medical cost offset phenomenon; it represents the endpoint where escalating medical spending failed to prevent a catastrophic outcome. By implementing benefit designs that are quantitatively linked to increased mortality, a plan sponsor is actively increasing the probability of incurring these maximum-cost scenarios. This is not a cost-saving strategy; it is a high-risk financial approach with severe human and economic consequences.

Section 10. Maximizing Harm: An Analysis of How PBM-Run Co-Payment Maximizer Programs Inflate Healthcare Costs and Burden Patients

The landscape of prescription drug affordability in the United States is increasingly shaped by complex and opaque programs designed by Pharmacy Benefit Managers (PBMs) and health plans. Among the most impactful and controversial of these are co-payment maximizer programs. While ostensibly created as cost-containment tools to counter manufacturer-sponsored patient assistance, this report finds that these programs inflict multifaceted harm on patients, payers, and the healthcare system at large. They represent a sophisticated form of financial engineering that shifts value from pharmaceutical manufacturers to PBMs, perversely incentivizes high drug prices, and imposes significant administrative and financial burdens on the chronically ill patients they claim to help.

This analysis dissects the architecture and systemic consequences of co-payment maximizer programs. It begins by detailing their mechanics, including the mandatory enrollment of patients into third-party vendor programs and the use of a regulatory loophole—reclassifying essential specialty medications as “non-essential health benefits”—to circumvent patient cost-sharing protections under the Affordable Care Act (ACA). The report clarifies the critical distinction between maximizers and their predecessors, co-payment accumulators, demonstrating that maximizers are a strategic evolution designed to be less disruptive to PBM-owned specialty pharmacy revenue streams while still capturing the full value of manufacturer assistance.

The investigation then illuminates the PBM profit engine, revealing how maximizer programs create a new revenue stream of “service fees” that are distinct from traditional rebates. By recharacterizing a significant portion of manufacturer assistance as a fee for program administration, PBMs can bypass increasingly common rebate pass-through contracts and retain a larger share of the funds, often without the full knowledge of the plan sponsors they serve.

Furthermore, the report documents the profound negative impact on patients. The administrative gauntlet of opaque enrollment processes, coupled with the illusion of a “zero-dollar” drug, creates a deferred financial shock. Because the substantial funds paid by manufacturers do not count toward a patient’s annual deductible or out-of-pocket maximum,

patients are left fully exposed to catastrophic costs for any other medical services they require, a phenomenon of "financial toxicity spillover."

The analysis extends to the macroeconomic effects on drug pricing, arguing that maximizers are a keystone in stabilizing the dysfunctional "high list price, high rebate" system. By neutralizing patient price sensitivity, these programs remove a critical market-based check on drug prices, creating a perverse equilibrium where both manufacturers and PBMs benefit from maintaining inflated list prices at the expense of systemic cost control. Finally, the report examines the complex regulatory environment, particularly the Medicaid "Best Price" rule, which inadvertently compels manufacturers to participate in the maximizer ecosystem as a perceived "safe harbor" from potentially catastrophic legal and financial risks associated with more direct forms of patient assistance.

The report concludes with targeted policy recommendations aimed at dismantling these harmful incentive structures. These include closing the "non-essential health benefit" loophole, mandating transparency in PBM fee structures, and fundamentally realigning PBM compensation to delink it from drug list prices. Implementing these reforms is critical to restoring a measure of rationality and fairness to the prescription drug market and protecting the vulnerable patients caught in the crossfire of these complex financial schemes.

The Architecture of Co-Payment Diversion: How Maximizer Programs Work

Co-payment maximizer programs do not exist in a vacuum; they are a strategic response by Pharmacy Benefit Managers (PBMs) and health insurance plans to a specific dynamic in the U.S. pharmaceutical market: the interplay between high patient cost-sharing and manufacturer-sponsored financial assistance. Understanding this foundational context is essential to deconstructing the complex and often harmful mechanics of the maximizer model. These programs represent a deliberate and engineered system for diverting the flow of funds intended to alleviate patient burden, redirecting that value to the benefit of the plan and the PBM. The architecture of this diversion relies on a combination of coercive enrollment practices, the manipulation of benefit design, and the exploitation of regulatory loopholes that undermine federal patient protection laws.

The Foundation: Manufacturer Co-Payment Assistance in a

High-Cost-Sharing Environment

In recent years, the design of commercial health insurance plans has increasingly shifted a greater share of healthcare costs onto patients through high deductibles, co-payments, and coinsurance.¹ For specialty prescription medicines, which can have list prices of thousands of dollars per month, this cost-sharing can be prohibitive, creating significant barriers to care.³ Patients facing coinsurance, which requires them to pay a percentage of the drug's cost rather than a flat fee, are particularly vulnerable.⁵ Studies have consistently shown that even small increases in out-of-pocket (OOP) costs can lead to reduced medication adherence, which in turn results in poorer health outcomes and higher downstream costs for the healthcare system.¹

In response to this access barrier, pharmaceutical manufacturers have widely implemented co-payment assistance programs, often in the form of coupons or debit cards.² These programs are designed to reduce or eliminate a commercially insured patient's immediate OOP costs at the pharmacy counter, thereby facilitating access to prescribed therapies and promoting adherence.⁷ In 2023 alone, the total value of this assistance was estimated at \$23 billion.⁴

Historically, the value provided by these manufacturer programs was treated like any other payment made by or on behalf of the patient. It counted toward the patient's annual deductible and OOP maximum.⁹ This meant that the assistance not only made a specific drug affordable but also helped the patient satisfy their total cost-sharing obligations for the year more quickly, after which the health plan would cover 100% of costs for all covered services.¹¹

However, PBMs and health plans view this dynamic as a direct threat to their cost-containment strategies. From their perspective, high cost-sharing is a deliberate feature of plan design, intended to create price sensitivity and steer patients toward preferred drugs on the formulary.⁸ By subsidizing the patient's copay for a non-preferred brand-name drug, manufacturer assistance effectively circumvents the plan's formulary design and neutralizes the financial incentives meant to control patients.⁸ This fundamental tension between the manufacturer's goal of ensuring market access and the payer's goal of controlling patients is the genesis of "co-payment adjustment programs" (CAPs), a category that includes both co-payment accumulators and the more sophisticated co-payment maximizers.¹⁴ These

programs were created with the express purpose of preventing manufacturer assistance from counting toward patient OOP limits, thereby capturing the financial benefit of the assistance for the plan rather than the patient.¹

The Maximizer Mechanism: Engineering the Exhaustion of Patient Support

The co-payment maximizer is a meticulously designed system that enables insurance plans to extract the full annual value of a manufacturer's co-payment assistance program. Unlike its predecessor, the co-payment accumulator, which often creates a sudden and disruptive financial shock for patients, the maximizer employs a more subtle, year-long approach that is ultimately just as harmful to a patient's overall financial health. This mechanism hinges on several key operational steps: mandatory enrollment through third-party vendors, the re-adjudication of patient cost-sharing to match the available assistance, and the critical legal maneuver of reclassifying targeted drugs as "non-essential health benefits."

The process typically begins when a PBM or a partnered third-party vendor identifies a patient who has been prescribed a specific high-cost specialty drug that is targeted by the program.⁸ These are often drugs for which substantial manufacturer co-payment assistance is available.¹⁴ The patient is then informed that they must enroll with a third-party organization to "assist them with affording their medications".⁸ This enrollment is not an optional value-added service but a mandatory and coercive condition for receiving the drug at an affordable price.⁸ Health plans notify patients that they can avoid extremely high cost-sharing only by signing up for the maximizer program.¹⁸ Should a patient choose not to participate, they are penalized with a substantial coinsurance obligation (e.g., 30%) based on the value of the forgone assistance, and critically, these punitive payments do not count toward their annual deductible or OOP maximum.¹⁴ This structure effectively leaves the patient with no viable choice but to enroll. During this process, the patient is required to provide personal and financial information to this unfamiliar third party and consent to have their pharmacy account monitored.⁸

Once the patient is enrolled, the third-party vendor's primary function is to calculate

the maximum annual value of the manufacturer's assistance program for that specific drug. For example, if a manufacturer offers up to \$15,000 per year in assistance, the vendor captures this figure.⁸ The vendor then advises the health plan or PBM to set the patient's monthly cost-sharing obligation for that drug to precisely exhaust this annual limit over the course of the year. In this example, the patient's new "copay" would be set to \$1,250 per month (\$15,000 divided by 12).¹⁷ The manufacturer's assistance funds are then applied to cover this newly inflated cost-sharing amount. The result at the pharmacy counter is that the patient often pays \$0 out-of-pocket for that specific medication, as the manufacturer's funds cover the entire fabricated "copay".⁸

This artificial inflation of the patient's cost-sharing obligation would typically be illegal for many health plans due to patient protection provisions in the Affordable Care Act (ACA), which establish annual limits on in-network OOP spending for essential health benefits.¹¹ To circumvent this critical protection, maximizer programs employ a key legal loophole: they reclassify the targeted specialty drugs as "non-essential health benefits" (EHBs).¹¹ This designation is not a clinical determination of the drug's medical necessity; it is a purely financial maneuver based on the drug's high cost and the availability of manufacturer assistance. By declaring a life-sustaining medication "non-EHB," the plan removes it from the ACA's protective umbrella, freeing the plan to set the patient's cost-sharing obligation for that drug at any level, including an amount far exceeding the statutory OOP maximum.¹¹ This weaponizes a provision of the ACA intended to provide benefit flexibility into a tool to undermine the law's core financial protections for patients.

The ultimate consequence of this intricate process is the core of the maximizer's harm: the thousands of dollars paid by the manufacturer on the patient's behalf are not credited toward the patient's annual deductible or OOP maximum.⁹ The plan successfully captures the full value of the manufacturer's assistance, using it to offset its own spending on the drug, while the patient makes no progress toward satisfying their overall cost-sharing liability for the year.

A Tale of Two Schemes: Differentiating Maximizers from Accumulators

While the terms are often used interchangeably, co-payment maximizers and co-payment accumulators are distinct program types with different operational mechanics

and impacts on the patient's financial journey, even though both share the same fundamental goal of preventing manufacturer assistance from counting toward OOP limits.¹ The market's clear and rapid shift away from accumulators and toward maximizers reveals a strategic evolution by PBMs to create a more financially sustainable model of value extraction that is less disruptive to their own core business operations.

Co-payment accumulator programs operate with a brute-force approach. They allow the patient to use the manufacturer's co-pay card at the pharmacy, but the system "accumulates" these payments in a separate, invisible bucket that does not count toward the patient's official deductible or OOP maximum.² The manufacturer's assistance funds are depleted as quickly as possible, often within the first few months of the plan year. Once the maximum value of the assistance is exhausted, the patient is abruptly confronted with a "copay cliff."⁴ They are suddenly responsible for the drug's full cost-sharing—which can be thousands of dollars—and must begin paying down their entire deductible from scratch.⁹ This sudden, massive, and often unexpected financial shock frequently leads to patients abandoning their prescriptions at the pharmacy, with devastating consequences for their health.⁹

Co-payment maximizer programs, in contrast, are designed to be "gentler" on the surface, avoiding the acute shock of the copay cliff.²⁶ As detailed previously, they smooth the application of the manufacturer's assistance evenly throughout the plan year, typically resulting in a consistent \$0 OOP cost for the patient for that specific drug.¹¹ This design choice is not born of benevolence. The high rates of treatment abandonment caused by accumulators represent a direct threat to a key PBM profit center: their own specialty pharmacies.²⁰ PBMs, particularly the large, vertically integrated entities, derive substantial revenue from dispensing high-margin specialty drugs.²⁰ When a patient abandons a prescription due to an accumulator's copay cliff, the PBM's specialty pharmacy loses that dispensing revenue. Maximizers solve this business problem. By ensuring the patient can continue to afford and access the targeted drug throughout the year, the maximizer program maintains a stable and predictable volume of high-margin prescriptions flowing through the PBM's affiliated pharmacy, preserving that crucial revenue stream.²⁰ Thus, the maximizer model represents a more sophisticated and financially advantageous strategy for the PBM itself, as it allows for the dual capture of value: the full manufacturer assistance is diverted to the plan, and the profitable dispensing volume is protected for the PBM's pharmacy business.

The market has responded accordingly, with data showing that the adoption of maximizers has rapidly outpaced that of accumulators.¹¹

The PBM Profit Engine: Reclassifying Rebates and Capturing Value

The proliferation of co-payment maximizer programs is driven by a powerful financial incentive for Pharmacy Benefit Managers. These programs are not merely cost-containment tools for their clients (health plans and employers); they are sophisticated profit centers for the PBMs themselves. The financial model of a maximizer program allows PBMs to capture a significant portion of manufacturer assistance through a mechanism that is more opaque and less regulated than the traditional rebate system. By structuring the diversion of funds as a "service fee" rather than a rebate, PBMs can circumvent client contracts that demand high rebate pass-through rates, creating a new, lucrative, and often hidden revenue stream. This financial shell game is further amplified by the PBM's ability to steer the guaranteed prescription volume generated by these programs to their own affiliated specialty pharmacies.

Beyond the Rebate: The Emergence of Maximizer "Service Fees"

The traditional PBM business model has long relied on negotiating substantial rebates from pharmaceutical manufacturers in exchange for favorable placement of a drug on a health plan's formulary.²⁷ PBMs typically retain a portion of these rebate dollars as profit before passing the remainder on to their plan sponsor clients.³² However, this rebate system has come under intense scrutiny from policymakers, employers, and the public, leading to increasing pressure for greater transparency and higher pass-through rates, with some contracts now requiring PBMs to remit 91% or more of rebate dollars to the plan sponsor.²⁷

Co-payment maximizer programs represent a strategic adaptation by PBMs to this changing environment. They create a new financial pathway for capturing manufacturer dollars that is deliberately structured to fall outside the definition of a "rebate." The third-party vendors that administer these programs—which are often either owned by or in exclusive partnership with the PBMs—charge a "service fee" for their role in managing the program.³³ This fee is not a negotiated discount on the price of the drug; it is presented as an

operational charge for the service of maximizing the plan's savings from manufacturer assistance programs.

Critically, this service fee is calculated as a direct percentage of the manufacturer assistance funds that are captured. Multiple industry analyses and reports indicate that this fee can be **"25% or more of the value of a manufacturer's copay support program"**.²⁰ For a specialty drug with a \$20,000 annual assistance program, this could amount to a \$5,000 fee. Through its ownership of or partnership with the vendor, the PBM is able to retain a substantial portion of this fee as direct revenue.²⁰ This shift from a rebate-based to a fee-based model of value extraction is a direct response to the growing pressure for rebate transparency. It allows the PBM to establish a new, less transparent channel for profiting from the manufacturer-payer transaction, effectively preserving its margins in the face of evolving market demands.

The Financial Shell Game: How Fee-Based Models Obscure Profit and Disadvantage Plan Sponsors

The reclassification of captured manufacturer funds from "rebates" to "service fees" is a financially significant maneuver that benefits the PBM at the expense of its own clients. While a plan sponsor's contract with its PBM may mandate a high pass-through rate for all negotiated rebates, these contractual terms typically do not apply to administrative or service fees.³³ This creates a loophole that PBMs can exploit.

The PBM can present the maximizer program to a plan sponsor (an employer, for example) as a pure cost-saving initiative. The employer sees a significant reduction in its net spending for a targeted specialty drug because the manufacturer's assistance is now covering what would have been the plan's liability. However, the employer is often unaware of the underlying financial mechanics. They may not know that before these "savings" were calculated, the PBM's vendor siphoned off as much as 25% of the total manufacturer assistance value as a service fee.²⁰

This creates a highly opaque system where the true value of the manufacturer's assistance is obscured. For instance, with a \$20,000 assistance program, a PBM vendor might take a \$5,000 fee, with the remaining \$15,000 being passed to the plan as "savings." The plan sponsor is pleased with the \$15,000 reduction in spend, but is unaware that the

program actually generated \$20,000 in value, a quarter of which was captured by their PBM partner as profit. This lack of transparency prevents plan sponsors from conducting an accurate cost-benefit analysis of the program and from negotiating more favorable terms. The Connecticut Office of Health Strategy's 2025 report on PBM practices explicitly identified "copay maximizer fees" as a distinct and growing source of PBM revenue, separate from rebate retention and other traditional sources, underscoring the materiality of this new profit center.³⁴

This fee-based model also creates a new and potent conflict of interest. A PBM's revenue from a maximizer program is directly proportional to the size of the manufacturer's assistance program.²⁰ This gives the PBM a direct financial incentive to grant favorable formulary status to drugs with the largest available co-pay assistance programs, as these will generate the highest fee revenue. This incentive can override the PBM's traditional fiduciary responsibility to select the drug with the lowest overall net cost for the plan sponsor. A PBM might favor a drug with a high list price and a \$20,000 assistance program over a therapeutically equivalent drug with a lower list price and a \$10,000 assistance program, because the former is more profitable for the PBM's maximizer business, even if the latter would be cheaper for the health plan.

Impact on PBM-Owned Assets: Driving Volume to Affiliated Specialty Pharmacies

The financial benefits of maximizer programs for PBMs extend beyond the collection of service fees. As established previously, a key feature of the maximizer model is its ability to maintain patient adherence to high-cost specialty medications by eliminating the "copay cliff" associated with accumulators.¹¹ This ensures a steady, predictable stream of prescriptions for these lucrative drugs throughout the year.

PBMs capitalize on this guaranteed volume by mandating that patients enrolled in maximizer programs must fill these prescriptions exclusively at the PBM's own affiliated specialty pharmacy.¹⁰ This practice, known as patient steering, is a cornerstone of the vertically integrated PBM business model.³⁶ By locking in patients, the PBM secures a high-margin revenue stream for its pharmacy division. This revenue is generated not only from dispensing fees but also from the "spread" between the price the PBM's pharmacy is

reimbursed by the health plan and the lower price at which it acquires the drug from a wholesaler or manufacturer.²⁷

The maximizer program thus functions as a powerful feeder channel for the PBM's most profitable assets. It transforms a manufacturer's patient support program into a tool that guarantees dispensing volume for the PBM's own pharmacy, creating a closed-loop system where the PBM profits at multiple points in the transaction: first, by capturing a portion of the manufacturer's assistance as a fee, and second, by profiting from the dispensing of the drug itself. This synergy between the maximizer program and the PBM's pharmacy business makes the model exceptionally profitable and explains its rapid proliferation in the market.

The Patient Gauntlet: Administrative Burdens and Financial Toxicity

While co-payment maximizer programs are engineered for financial efficiency from the perspective of the PBM and payer, they impose a significant and often overwhelming burden on patients. This burden is not merely financial; it is also administrative and psychological. Patients with serious and chronic illnesses are forced to navigate an opaque, complex, and coercive system at a time when they are most vulnerable. The surface-level benefit of a "zero-dollar" copay for one medication masks a much deeper financial harm, creating a deferred but potent form of financial toxicity that can compromise a patient's access to all other forms of healthcare. The administrative complexity of these programs is not an unfortunate byproduct but a strategic feature that creates friction and opacity, benefiting the program operators by discouraging scrutiny and isolating the patient.

Navigating the Labyrinth: The Opaque Enrollment and Administration Process

For most patients, their introduction to a maximizer program is an unexpected and confusing event. They are often entirely unaware that their health plan includes such a program, as the details are frequently buried in plan documents under euphemistic and misleading names like "Out-of-Pocket Protection Program" or "Benefit Plan Protection Program".⁹ The lack of transparency is a defining feature, with many patients only learning of the program's existence when they are contacted by an unfamiliar third-party vendor and told

they must enroll to continue receiving their medication affordably.²

This mandatory enrollment process represents a significant administrative hurdle. Patients, who are often already managing a complex medical condition, are required to engage with a new entity, provide sensitive personal and financial information, and consent to have their pharmacy records monitored.³ This additional step inevitably creates delays in accessing essential medication, as the patient cannot fill their prescription until the enrollment and coordination are complete.²

Furthermore, the system's inherent complexity, which requires seamless coordination between the PBM, the third-party vendor, and the specialty pharmacy, is highly susceptible to errors. If the vendor fails to correctly manipulate the patient's copay in the claims system after the manufacturer's funds are applied, the patient can be confronted with an incorrect and unexpectedly high bill at the pharmacy counter.⁴ Resolving these billing issues requires further intervention, often forcing the pharmacy to request a manual override from the plan, leading to additional delays and immense frustration for the patient.⁵ This complexity also increases the administrative workload for physicians' offices, whose staff must now attempt to understand the nuances of these arcane programs and help their distressed patients navigate them, taking time away from clinical care.²

The Illusion of "Zero-Dollar" Drugs: Hidden Costs and Deferred Financial Shocks

The most insidious aspect of the co-payment maximizer is the false sense of financial security it provides. By engineering a patient's OOP cost for their targeted specialty drug to be \$0, the program appears to be a benevolent benefit.⁶ However, this is a dangerous illusion that masks a severe, underlying financial harm. The core mechanism of the maximizer is to ensure that none of the thousands of dollars paid by the manufacturer on the patient's behalf are credited toward their annual deductible or OOP maximum.⁶

This has profound consequences for the patient's ability to afford any other healthcare they may need throughout the year. A patient with a \$5,000 deductible and a specialty drug subjected to a maximizer program might see \$15,000 paid by the manufacturer over the course of the year, yet at the end of the year, their plan will still consider them to have paid \$0

toward their deductible. This leaves them fully and unexpectedly exposed to the entire cost of their deductible and subsequent cost-sharing for any other medical needs, such as physician visits, lab tests, emergency room care, hospitalizations, or prescriptions for other conditions.⁸

This phenomenon can be described as "financial toxicity spillover." A program designed to manage the cost of a single drug makes all other healthcare financially toxic for the patient. This fundamentally redefines the nature of insurance risk. A health plan is a contract in which an insurer accepts premiums in exchange for assuming the financial risk of a member's healthcare needs. The maximizer program subverts this principle. It effectively transfers the financial risk for the high-cost specialty drug from the insurer to the drug manufacturer. Simultaneously, by preventing any progress toward the OOP limit, it transfers the financial risk for all other healthcare costs from the insurer back to the chronically ill patient. The insurer successfully offloads its primary liabilities while continuing to collect premiums and ensuring the patient remains on the hook for their full cost-sharing obligations.

The Human Cost: Patient Confusion, Treatment Abandonment, and Health Inequity

The combination of administrative complexity and hidden financial risks exacts a heavy human toll. The lack of transparency leads to widespread patient confusion, anxiety, and stress.² Patient advocacy groups, such as the All Copays Count Coalition, consistently report that these programs disproportionately harm individuals with serious and chronic conditions like cancer, autoimmune diseases, and HIV, as these are the patients most likely to rely on the expensive specialty medications targeted by maximizers.¹⁸

While maximizers are designed to prevent the abandonment of the targeted drug, the overall financial strain they create can force patients into impossible choices. Faced with their full, unmet deductible when an unrelated health issue arises, patients may be forced to forgo or delay necessary medical care, ration other medications, or accumulate medical debt.² This can lead to the progression of disease, avoidable hospitalizations, and ultimately, poorer health outcomes and higher long-term costs for the entire healthcare system.²⁴

There is also growing concern that these programs may exacerbate existing health inequities. One analysis found that non-White and historically marginalized populations were more likely to be enrolled in plans with these harmful benefit designs.²⁹ By placing the

greatest financial burden on the sickest and most vulnerable patients, maximizer programs can widen disparities in access to care and health outcomes. The administrative complexity is not an accident; it is a feature that serves the program's operators. The opaque, multi-layered system involving unfamiliar third parties creates friction that isolates patients, discourages scrutiny, and makes it exceedingly difficult for even sophisticated employers to track the flow of funds and understand the program's true financial impact. This manufactured complexity provides cover for the fee-extraction model and solidifies the PBM's control over the patient's benefits.

The Inflationary Spiral: How Maximizers Perpetuate High Drug Prices

Contrary to the claims of PBMs and payers that co-payment maximizer programs are tools for controlling escalating drug costs, a deeper economic analysis reveals that they are an integral component of the very system that drives price inflation. These programs do not solve the problem of high drug prices; they perpetuate it. By insulating key actors from the market consequences of high list prices, maximizers help sustain a perverse and dysfunctional pricing equilibrium that benefits intermediaries like PBMs and distributors. They neutralize the primary cost-control levers of modern benefit design and create a stable environment in which the "high list price, high rebate" model can continue to thrive, ultimately increasing costs for the healthcare system as a whole.

The Symbiotic Relationship Between High List Prices and PBM/Distributor Revenue

To understand the inflationary impact of maximizers, one must first recognize that the business models of key pharmaceutical supply chain intermediaries are often directly and positively correlated with high drug list prices, also known as the Wholesale Acquisition Cost (WAC).³¹

For PBMs, a primary source of revenue is the negotiation of rebates from manufacturers. These rebates are almost always calculated as a percentage of the drug's list price.³¹ Consequently, a drug with a higher list price can generate a larger dollar-value rebate, even if the net price after the rebate is the same as a lower-priced competitor. This dynamic

creates an incentive for PBMs to favor drugs with high list prices and high rebates on their formularies, as it allows them to demonstrate greater "savings" to their clients and potentially increases their retained portion of the rebate.²⁷ Empirical research has quantified this effect, finding that, on average, a \$1.00 increase in negotiated rebates is associated with a \$1.17 increase in the drug's list price, confirming that the demand for higher rebates directly fuels list price inflation.⁴² PBMs can also profit from "spread pricing," a practice where they charge a health plan a higher price for a drug than they reimburse the pharmacy. The size of this "spread" is often larger for more expensive drugs, again tying PBM profitability to high list prices.²⁷

Pharmaceutical wholesalers, the entities that distribute drugs from manufacturers to pharmacies, also benefit from high list prices. Their revenue is derived from fees and markups that are often tied to the WAC.⁴³ Furthermore, they can profit from manufacturer price increases through a practice known as "forward buying," where they purchase and stockpile inventory at a lower price before a planned price increase and then sell it at the new, higher price, capturing the difference.⁴³

A Perverse Cycle: Why Maximizers Incentivize Manufacturers to Maintain or Increase List Prices

The interplay of these dynamics creates a stable, perverse feedback loop where high list prices become advantageous for the most powerful players in the system. In a market without maximizers, a manufacturer that sets an extremely high list price would face significant pushback. Payers would place the drug on a high tier with prohibitive coinsurance, and even with co-pay assistance, the high price would be a point of contention in negotiations. Maximizer programs resolve this tension and create a state of equilibrium that benefits both the manufacturer and the PBM. The system works as follows:

1. **The Manufacturer's Position:** The manufacturer can maintain or even increase a high list price. This high price is necessary to accommodate the large, percentage-based rebates demanded by PBMs for formulary access. It also allows the manufacturer to fund a large co-payment assistance program, which is essential to ensure patients can overcome the high cost-sharing barriers created by that same high list price.³¹

2. **The PBM/Payer's Position:** The PBM implements a maximizer program. This program captures the entire value of the manufacturer's large assistance program, converting it into direct savings for the health plan and lucrative fee revenue for the PBM.¹⁷

In this closed loop, the high list price is no longer a problem to be solved; it is a prerequisite for the system to function profitably for the intermediaries. The manufacturer secures market access for its drug, the PBM profits from both the high-rebate environment and the direct fees from the maximizer program, and the health plan sees a reduced net cost for that specific drug. The only losers are the broader healthcare system, which must absorb the inflationary effects of ever-increasing list prices, and the patient, who, as detailed in the previous section, faces catastrophic financial risk for all other health services.⁴⁵ The maximizer, therefore, acts as a "keystone" that locks the dysfunctional high list price/high rebate system into place, making it a sustainable and mutually beneficial strategy for the most powerful market participants. This represents a fundamental shift in the PBM's role, from an agent intended to manage drug utilization and costs to one that manages and harvests third-party subsidies, a role whose profitability depends on the very price inflation it is supposed to control.

A Calculated Risk: Why Manufacturers Participate in the Maximizer Ecosystem

At first glance, a pharmaceutical manufacturer's willingness to fund a multi-billion-dollar assistance program only to see its value systematically captured by PBMs and health plans appears paradoxical. Why would a manufacturer willingly participate in a system that diverts funds intended to help patients? The answer lies not in a preference for the maximizer model, but in a calculated assessment of risk within a complex and punitive regulatory environment. The primary driver of this behavior is the formidable power of the Medicaid "Best Price" rule, a federal statute that carries the potential for catastrophic financial penalties. Faced with the legal tightrope created by this rule, manufacturers may view the convoluted financial architecture of a co-payment maximizer as a "safer," albeit still undesirable, alternative to more direct forms of patient assistance that carry greater regulatory risk.

The Medicaid "Best Price" Rule: A High-Stakes Compliance Challenge

The Medicaid Drug Rebate Program (MDRP) is a cornerstone of federal and state efforts to control prescription drug spending. A central provision of the MDRP is the "Best Price" rule, which mandates that a drug manufacturer must provide Medicaid with a rebate that ensures the program receives the lowest price offered to nearly any commercial or private purchaser in the United States.⁴⁶ Specifically, the rebate for a brand-name drug is the greater of either 23.1% of the Average Manufacturer Price (AMP) or the difference between the AMP and the "Best Price".⁴⁸

The statute defines "Best Price" as the lowest price available from the manufacturer to "any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity".⁴⁹ The list of these "best price eligible entities" is critical because it does not include patients. The existential risk for a manufacturer is that if its co-payment assistance is legally interpreted as a price concession or discount that benefits a health plan or PBM (both of which are best price eligible entities) rather than accruing solely to the patient, the entire value of that assistance could be used to calculate a new, much lower "Best Price" for the drug.⁵⁰

The financial consequences of such a reclassification would be devastating. If a manufacturer provides \$15,000 in co-pay assistance for a drug, and this is deemed a discount to the plan, the drug's "Best Price" could plummet. This new, lower Best Price would then be used to calculate the mandatory rebate owed to Medicaid programs in all 50 states, potentially resulting in hundreds of millions or even billions of dollars in retroactive rebate liabilities.⁴⁶ This high-stakes compliance challenge forces manufacturers to be exceedingly cautious about how their assistance programs are structured and how the value is perceived to flow through the healthcare system.

The 2020 CMS Final Rule and Its Aftermath: A Legal Tightrope for Manufacturers

The regulatory threat associated with Best Price became acute in December 2020, when the Centers for Medicare & Medicaid Services (CMS) issued a final rule that directly targeted co-payment accumulator and maximizer scenarios. The rule stated that beginning January 1, 2023, manufacturer assistance would have to be included in Best Price calculations

if the full value of that assistance was not passed on to the patient.⁵² This rule effectively put manufacturers in an impossible position: they would be held responsible for "ensuring" that the value of their assistance was not captured by payers, a task made difficult by the opaque and complex systems that PBMs control.⁵⁴ The rule created immense financial uncertainty, threatening the viability of all co-payment assistance programs.

In response, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a lawsuit challenging the rule. In May 2022, the U.S. District Court for the District of Columbia vacated the rule, handing the industry a significant victory.⁵⁰ The court's reasoning was based on a literal interpretation of the statute: since assistance is provided to patients, and patients are not on the list of "best-price-eligible purchasers," CMS had exceeded its authority by requiring these funds to be included in the Best Price calculation.⁵⁰

Despite this favorable ruling, the legal environment remains uncertain. The court's decision hinged on a legal formalism—the direct recipient of the funds—rather than the economic reality of who ultimately benefits. The underlying threat persists that a future administration could issue a new rule, or a different court could interpret the statute differently, leaving manufacturers on a precarious legal tightrope.¹ This lingering risk continues to heavily influence manufacturer strategy regarding patient assistance.

Maximizers as a "Safe Harbor": Why the Program's Structure Offers a Perceived Shield from "Best Price" Liability

Given this high-risk regulatory landscape, the convoluted structure of the co-payment maximizer program, while financially inefficient for the manufacturer, may offer a perceived legal advantage over more direct forms of assistance that are subject to a simple accumulator. Federal regulation (specifically, 42 CFR § 447.505) states that manufacturer co-payment assistance is excluded from Best Price calculations only "to the extent that the program benefits are provided entirely to the patient and the pharmacy, agent, or other entity does not receive any price concession".⁵¹

In a straightforward co-payment accumulator scenario, the financial trail is relatively clear. The manufacturer's payment directly reduces the amount the health plan has to pay for the drug, making a strong argument that the plan has received a direct price concession. This creates a significant legal risk for the manufacturer under the Best Price statute.

The maximizer model, however, introduces layers of separation and recharacterization that muddy the financial waters. The manufacturer's funds do not flow directly to the plan. Instead, they flow to a third-party vendor, which then uses those funds to cover an artificially inflated "patient cost-share." The PBM, in turn, receives a "service fee" for administering the program.²⁰ This complex pathway allows the transaction to be framed not as a discount on the drug's price to the payer, but as a payment to a vendor for a "patient support service." This creates legal ambiguity. It becomes more difficult for a regulator to definitively prove that the manufacturer provided a direct price concession to a best-price-eligible entity.

This gap between the legal form of the transaction (a payment to a patient's benefit via a vendor) and its economic substance (the value is captured by the payer) creates the gray area in which the maximizer model thrives. While manufacturers are undoubtedly harmed by having the full value of their assistance programs captured, they may calculate that this known financial loss is preferable to the unknown but potentially catastrophic risk of a Best Price violation. Therefore, the existence of the powerful but blunt Best Price rule has the unintended consequence of fostering more complex and opaque business practices in the commercial market, as all parties are incentivized to create convoluted financial arrangements to avoid triggering its punitive effects.

Section 11. The Wholesaler Oligopoly: An Analysis of Market Control, Price Inflation, and Supply Chain Fragility in U.S. Pharmaceutical Distribution

The U.S. pharmaceutical distribution system, a critical component of national healthcare infrastructure, is dominated by a highly concentrated oligopoly. Three companies—Cencora (formerly AmerisourceBergen), Cardinal Health, and McKesson, collectively known as the “Big Three”—control over 90% of the market, creating a system that functions with the power of a de facto monopoly.¹ This report provides an exhaustive analysis of the interlocking mechanisms through which this oligopoly exercises its market power to artificially inflate pharmaceutical prices for providers and patients, exert unsustainable financial pressure on manufacturers, and contribute directly to the persistent and growing crisis of drug shortages.

The analysis demonstrates that the Big Three’s market control is not merely a function of their size, but is actively maintained and exploited through a sophisticated architecture of contractual and structural arrangements. This report deconstructs seven key mechanisms that, in concert, create a self-reinforcing system of value extraction and competitive foreclosure:

1. **Generic Compliance Ratios (GCRs):** These contractual requirements, embedded in Prime Vendor Agreements, function as anticompetitive tying arrangements. By linking essential rebates and favorable pricing on monopolized brand-name drugs to a pharmacy’s purchasing volume of generic drugs, wholesalers effectively force pharmacies to source generics from them, even at inflated prices, thereby locking out smaller, more competitive secondary wholesalers.³
2. **Wholesaler-Owned Pharmacy Services Administrative Organizations (PSAOs):** The Big Three have achieved a form of “soft” vertical integration by owning the PSAOs that represent over 75% of independent pharmacies.⁵ This creates a profound conflict of interest, transforming these organizations from agents of the pharmacies into enforcement arms for the wholesalers, steering their members into the very contracts that limit their autonomy and financial viability.⁶

3. **Generic Sourcing Alliances:** Through joint ventures such as Red Oak Sourcing (Cardinal Health/CVS) and ClarusONE (McKesson/Walmart), the wholesalers have consolidated over 90% of the nation's generic drug purchasing power.⁸ This extreme monopsony power allows them to drive manufacturer prices down to unsustainable levels, leading directly to market exits, a lack of manufacturing redundancy, and chronic drug shortages for critical medicines.¹⁰
 4. **The Price Paradox:** The wholesalers exploit their dual-sided market power to simultaneously squeeze manufacturers on price while inflating the costs for pharmacies. They use their sourcing alliances to acquire generics at artificially low prices and then use GCRs to sell those same drugs to a captive pharmacy market at markups estimated to be as high as 200%, compared to just 1% for brand-name drugs.¹²
 5. **Coercive Contract Clauses:** One-sided contractual terms are weaponized to discipline market participants. "Failure to Supply" (FTS) clauses penalize manufacturers who cannot meet demand at the unsustainably low prices the wholesalers dictate, while "Right of First Refusal" (ROFR) clauses allow wholesalers to neutralize competitive threats from secondary suppliers without engaging in proactive price competition.¹¹
 6. **Financial Engineering via "Float":** By enforcing short payment cycles on pharmacies while negotiating extended terms with manufacturers, wholesalers operate with a highly favorable cash conversion cycle. This allows them to hold and invest billions of dollars in "float"—capital paid by their customers before they must pay their suppliers—generating substantial profits at the expense of the financial stability of other supply chain participants.¹⁵
 7. **Pharmacy Switch Surveillance:** The ownership of the two dominant pharmacy switches—Relay Health (McKesson) and Change Healthcare (UnitedHealth/Optum)—transforms neutral data infrastructure into a proprietary surveillance system.¹⁷ A pharmacy switch acts as a router for prescription drug claims. By accessing real-time pharmacy dispensing data, wholesalers can perfectly monitor and enforce compliance with GCRs, making it virtually impossible for pharmacies to deviate from their restrictive contracts. It is no longer feasible to change how much they are paid, by who, and whether they charge everyone the same or use fees as leverage.¹⁸
- This report concludes that these are not disparate issues but are integral components of a

single, highly effective system of market control. The resulting price inflation and supply chain fragility are not market failures but are the predictable outcomes of a system designed to maximize value extraction for the oligopoly.

The Architecture of an Oligopoly: Market Concentration in U.S. Drug Wholesaling

In addition to the broken dynamics of the pharmaceutical benefit managers, a key component of the market distortions and anticompetitive practices within the U.S. pharmaceutical supply chain is the concentration of power within the wholesale distribution sector. This market is a mature and stable oligopoly dominated by three colossal entities: Cencora (the new name for AmerisourceBergen), Cardinal Health, and McKesson Corporation.¹ Together, these "Big Three" wholesalers function as the indispensable intermediaries, the central gatekeepers through which nearly every prescription drug in the United States must pass. Their sheer scale when combined with their agreements and ventures with PBMs (and the entities that own the PBMs, insurance carriers), creates a unique web of control that allows them to distribute "the spoils" of every margin dollar in the entire pharmacy supply chain, from insurance plan to the lowest price generics, and patient out of pocket costs.

The market share controlled by the Big Three is staggering and has steadily increased over the past decade. Combined, these companies manage the distribution of over 90% of all pharmaceutical and medical products in the United States.¹ Analysis from 2018 estimated their combined share of the drug distribution channel to be as high as 95%, an increase from 87% in 2013.² This growth was fueled by a combination of acquisitions of smaller wholesale distributors and strategic shifts by large retail pharmacy chains to source their generic drugs through these primary wholesale channels.² This level of concentration means that for both pharmaceutical manufacturers seeking to bring a drug to market and for pharmacies seeking to procure inventory, engaging with at least one of the Big Three is not a choice but a necessity. They are, for all practical purposes, the market itself.

The financial scale of these operations is commensurate with their market dominance. In 2024, the combined drug distribution revenues for the Big Three were \$776 billion.¹⁵ This market structure has allowed the Big Three to perfect a simple but profoundly effective

business model, succinctly described as: "Buy low, sell high, collect early, and pay late".¹⁵ Each component of this model is predicated on the exercise of market power. They leverage their immense purchasing volume to "buy low" from manufacturers, dictate terms to "sell high" to pharmacies, enforce strict payment schedules to "collect early" from those pharmacies, and use their critical role to "pay late" to manufacturers. The subsequent sections of this report will systematically deconstruct how each of these objectives is achieved through specific contractual and structural mechanisms.

It is crucial to understand that the U.S. pharmaceutical wholesale market is not a dynamic environment where three firms fiercely compete on price and terms. Rather, it is a stable oligopoly where competition is managed and market share is largely reallocated among the incumbents. Recent shifts in primary wholesale relationships among major healthcare players illustrate this point perfectly. For instance, UnitedHealth Group's Optum Rx business shifted its primary relationship from Cardinal Health to McKesson, while the supermarket chain Publix moved its business from Cencora to Cardinal Health.¹⁵ On the surface, these changes might suggest a competitive landscape. However, the critical observation is that these massive contracts are not moving to a new, disruptive fourth player; they are simply being shuffled among the existing members of the oligopoly. This dynamic demonstrates that even the largest and most sophisticated purchasers in the healthcare system lack a viable competitive alternative outside the Big Three. The barriers to entry for a new, full-line national wholesaler are effectively insurmountable, given the required logistical infrastructure, manufacturer relationships, and capital. Consequently, these shifts do not represent market disruption but rather a reinforcement of the closed, stable nature of the oligopoly, where the members may compete for share from one another but face no existential threat from outside competition. This stability is the bedrock upon which their collective market power is built. To provide a clear, quantitative foundation for the analysis that follows, the market concentration is summarized below.

Wholesaler	Individual Market Share (%)
McKesson Corporation	30%
Cardinal Health	31%
Cencora (AmerisourceBergen)	29%

Data compiled from sources ¹ and ²¹

This table codifies the architecture of the oligopoly. With individual market shares clustering around 30% each, no single firm dominates, but their collective control is nearly absolute. It is from this position of shared market dominance that the Big Three are able to individually and collectively impose the terms and structures that define the economics of the entire pharmaceutical supply chain.

The Gatekeepers: How Generic Compliance Ratios Erect Barriers to Competition

Among the most powerful yet least understood tools used by the Big Three wholesalers to maintain their market dominance are the contractual clauses known as Generic Compliance Ratios (GCRs). Far from being a simple measure of purchasing efficiency, GCRs function as a highly effective anticompetitive mechanism. They are designed to lock pharmacies into a dependent relationship with their primary wholesaler, effectively foreclosing the market to smaller, often lower-priced, secondary wholesalers. By leveraging their control over the supply of essential brand-name drugs, the Big Three use GCRs to create a "rebate trap" that makes it financially irrational for a pharmacy to seek better prices for generic drugs elsewhere, thereby protecting the wholesalers' inflated generic margins.

A GCR is defined within a pharmacy's Prime Vendor Agreement (PVA) as the percentage of its total prescription drug purchases that are generic medications sourced from that primary wholesaler.¹⁹ The formula is straightforward: the dollar amount of generic drugs purchased from the primary wholesaler divided by the total dollar amount of all prescription drugs purchased from that wholesaler. Wholesalers present this metric as a benchmark for a pharmacy's profitability and purchasing discipline. However, its primary function is to serve as the gateway to a complex system of tiered rebates and discounts that are the lifeblood of a pharmacy's financial viability.¹⁸

Wholesaler contracts are structured to provide significant penalties for violating this ratio. The most significant of these is the generic rebate, which is typically organized into multiple tiers based on the pharmacy's GCR.⁴ A pharmacy that achieves a GCR of 98%, for example, might receive a 30% rebate on all its generic purchases for the month. If its

compliance drops to 94%, that rebate might fall to 25%. For an average independent pharmacy, this seemingly small percentage change can translate into thousands of dollars in lost income.⁴ Furthermore, these GCRs are often linked to other crucial financial terms, including the size of the discount the pharmacy receives on its brand-name drug purchases.¹⁸

This structure creates a perilous financial dynamic for any pharmacy attempting to lower its cost of goods by purchasing from secondary suppliers. A secondary wholesaler can often offer specific generic drugs at a price significantly lower than the primary wholesaler's. In fact, pharmacies have told us that cost plus drugs offers pieces to patients lower than what they can buy the same drugs from the big 3 wholesalers for, even after all rebates. A rational pharmacy owner, seeking to maximize profit, would naturally "chase" these cheaper deals. However, the GCR system turns this rational decision into a potentially devastating financial misstep.

Consider a hypothetical but realistic scenario based on this contractual structure: An independent pharmacy identifies an opportunity to save \$100 on a single order of imatinib from a secondary supplier. On an item-by-item basis, this is a clear win. However, by shifting that purchase away from its primary wholesaler, the pharmacy's GCR for the month might slip from a higher tier to a lower one. As documented in analyses of these contracts, this could trigger a reduction in the pharmacy's overall generic rebate from 30% to 25%. For a pharmacy spending \$60,000 per month on generics, this drop in the rebate rate results in a net loss of \$3,000 for the month.⁴ The initial \$100 savings is dwarfed by the subsequent penalty. This "rebate trap" effectively punishes pharmacies for seeking competitive prices and compels them to purchase generics from their primary wholesaler, even when they know the price is higher than the market value available elsewhere.³

This mechanism functions as a sophisticated tying arrangement. In a classic tying scheme, a seller with market power over one product (the "tying" product) forces a buyer to also purchase a second, different product (the "tied" product). In this case, the Big Three wholesalers hold de facto monopoly power over the distribution of the full portfolio of brand-name drugs. A pharmacy cannot operate without reliable access to these products, making them an essential, "must-have" tying product. The wholesalers leverage this power by making favorable financial terms on brand drugs—the very products where they face no competition—contingent upon the pharmacy meeting a high GCR. This forces the pharmacy to also purchase the "tied" product: generic drugs. This is particularly pernicious because the

generic market is, in theory, a competitive one. By tying the two together, the wholesalers use their monopoly power in the non-competitive brand market to foreclose competition and protect their inflated margins in the competitive generic market. Secondary wholesalers, who cannot offer the comprehensive portfolio of brand-name drugs, are thus unable to compete effectively, regardless of how low their generic prices are.

Furthermore, the sheer complexity of these contracts creates a significant information asymmetry that wholesalers exploit to maintain control. The final, true cost of any single drug is not its invoice price. It is a function of a dizzying array of factors: multiple tiered rebate structures for generics and brands, volume commitments, formulary requirements, and payment terms.⁴ To know with certainty whether purchasing a single item from a secondary supplier will result in a net financial gain or loss requires a daily, dynamic recalculation of the pharmacy's entire purchasing portfolio against the intricate terms of its PVA.⁴ Most independent pharmacies lack the specialized staff, software, and time to perform this constant, complex analysis. Faced with this uncertainty and the credible threat of losing thousands of dollars in rebates, the path of least resistance and lowest risk is to simply default to purchasing everything from the primary wholesaler. This is a form of control through calculated obfuscation, reinforcing the wholesaler's power by making the true costs of deviation unknowable.

The following table illustrates the financial trap created by a typical GCR rebate structure, demonstrating how a small deviation in purchasing behavior can lead to a significant net financial loss.

GCR Tier	Generic Rebate Percentage	Monthly Rebate on \$100k Generic Spend	Hypothetical Savings from Secondary Wholesaler	Net Gain/Loss from "Chasing Savings"
Tier 1: 95-100%	30%	\$30,000	N/A	Baseline
Tier 2: 90-94.9%	25%	\$25,000	\$1,000	-\$4,000
Tier 3: 85-89.9%	20%	\$20,000	\$2,000	-\$8,000

This table is an illustrative model based on the tiered incentive structures described in source.⁴ It assumes a pharmacy with \$100,000 in monthly generic spend. A purchase from a secondary supplier saves \$1,000 but causes the GCR to drop from Tier 1 to Tier 2, resulting in a \$5,000 reduction in rebates and a net loss of \$4,000.

As the table demonstrates, the penalty for non-compliance far outweighs the potential

reward. This coercive financial structure is a primary reason why the secondary wholesale market has been unable to gain a meaningful foothold and why the Big Three are able to maintain artificially high prices on generic drugs sold to their captive pharmacy customers. This restriction of course impacts the cost to patients, particularly the uninsured or those with High deductible plans. If a pharmacy could buy at the lowest available price, they can sell to any patient at the lower price. Unfortunately, the GCR trap prevents this. Leaving the pharmacy to sell to the patient at a price higher than it should be. The same applies to self insured employers. This benefits not only the wholesaler, but also the PBM who can now charge a higher price and has the opportunity to mark up or spread the pricing to the employer. Without the employers knowledge that this GCR policy and the PBMs refusal to contest it, is costing employers and patients

The Captive Network: Wholesaler-Owned PSAOs and the Erosion of Independent Pharmacy Autonomy

The market power of the Big Three wholesalers is not confined to the logistics of drug distribution; it extends deep into the administrative and financial operations of their most profitable customers: independent pharmacies. For the purpose of this report we define any pharmacy that is not owned or affiliated with a big 3 PBM. This influence is exerted through a powerful and often overlooked form of vertical integration—the ownership of Pharmacy Services Administrative Organizations (PSAOs). While ostensibly created to help independent pharmacies, wholesaler-owned PSAOs function as a critical tool for customer capture and control. They create a profound conflict of interest that transforms them from advocates for pharmacies into enforcement arms for their parent wholesalers, effectively stripping independent pharmacies of their autonomy and locking them into the wholesalers' anticompetitive ecosystem.

PSAOs are intermediary entities that provide a range of "back-office" services to independent pharmacies, which lack the scale and resources of large chains.⁵ Their most critical function is the collective negotiation of contracts with powerful Pharmacy Benefit Managers (PBMs).⁵ By aggregating thousands of independent pharmacies into a single network, a PSAO can theoretically achieve more favorable reimbursement rates and contract terms than a single pharmacy could on its own.²⁶ Approximately 83% of all independent

pharmacies in the U.S. utilize the services of a PSAO, making them a central feature of the community pharmacy landscape.⁵

The critical issue, however, lies in the ownership of these influential organizations. The majority of PSAOs are not independent, pharmacy-owned cooperatives. Instead, they are owned and operated by the Big Three wholesalers themselves.⁶ An estimated 75% of independent and small-chain pharmacies are members of a PSAO owned by Cencora, Cardinal Health, or McKesson.⁵ This vertical integration creates an immediate and irreconcilable conflict of interest. The entity tasked with representing the pharmacy's best interests in contract negotiations is owned by the pharmacy's largest supplier and, frequently, its largest creditor.

Investigations and industry reports have confirmed that this conflict is not merely theoretical. A Government Accountability Office (GAO) report found that while most PSAO owners claimed their PSAO business line earned little to no profit, they acknowledged operating the PSAO to provide benefits to their *non-PSAO* line of business—namely, drug distribution.⁶ The mechanism for leveraging this conflict is direct and coercive. The GAO found that some wholesaler-owned PSAOs explicitly limit their services to pharmacies that are already customers of their drug distribution business.⁶ In practice, this means that for an independent pharmacy to gain access to the PBM networks and administrative support offered by a dominant PSAO, it must first agree to source its drugs from the PSAO's parent company.

This arrangement effectively transforms the PSAO into a powerful customer acquisition and retention tool for the wholesaler. It creates a closed loop: an independent pharmacy, needing to contract with PBMs to serve insured patients, joins the largest and most powerful PSAO available, which is owned by a wholesaler. As a condition of joining, or through strong-armed contractual terms, the pharmacy is then funneled into a Prime Vendor Agreement with that same wholesaler. This PVA will inevitably contain the restrictive Generic Compliance Ratios (GCRs) and other unfavorable terms discussed previously. The PSAO, which should be the pharmacy's advocate, instead becomes the instrument that traps the pharmacy in an undesirable and often financially disadvantageous purchasing contract.

This structure represents a form of "soft" vertical integration that achieves the same anticompetitive results as a direct merger but with far less regulatory scrutiny. By controlling the administrative and contracting agent for thousands of nominally "independent"

pharmacies, the wholesaler gains effective control over their collective purchasing decisions without the need for direct ownership. The PSAO is marketed to pharmacies as a lifeline, a way to gain "significant bargaining clout" and compete with larger chains.²⁶ In reality, for the majority of pharmacies contracting with a wholesaler-owned PSAO, this aggregated power is wielded not for their benefit, but for the benefit of the wholesaler's primary business. The PSAO is meant to "negotiate" with PBMs on one side. However, given the business relationships wholesalers have with the big 3 PBMs, there is an inherent conflict of interest present and a motivation to strike poor deals for the independent pharmacies within a PSAO. PBM contracts negotiated by PSAOs almost always reimburse brand drugs under the cost of medications. Payment terms result in independent pharmacies carrying significant float risk for PBMs. The PSAOs may hold themselves out as negotiating on behalf of independent pharmacies, but are in fact more closely tied financially to the large PBMs they are meant to negotiate against.

Effectively, the more important, albeit less transparent, function of PSAOs is to ensure a steady, compliant, and captive customer base for its parent company. This dynamic neutralizes the very independence that defines community pharmacy. A pharmacy's most critical business decisions are procurement and reimbursement—the ability to source its primary product, pharmaceuticals, at the best possible price. When its agent in the marketplace (the PSAO) is owned by its primary supplier (the wholesaler), this independence is rendered illusory. The pharmacy is no longer an autonomous actor seeking the best terms in an open market; it is a captive node in a vertically integrated supply chain, with its choices constrained and its profitability squeezed to serve the interests of the dominant player at the center. This structural conflict of interest is a key enabler of the oligopoly's power, allowing it to extend its control from the warehouse dock directly into the back office of thousands of community pharmacies across the country.

Monopsony Power in Action: The Impact of Generic Sourcing Alliances

While the Big Three wholesalers exert oligopoly power over their pharmacy customers, they exert a different but equally potent form of market control over their suppliers: monopsony power. A monopsony exists when there is effectively only one buyer for a given

product, granting that buyer immense leverage to dictate prices and terms. In the U.S. generic drug market, the wholesalers, in partnership with the largest pharmacies and PBMs, have strategically engineered such a structure through the creation of massive generic sourcing Group Purchasing Organizations (GPOs). These alliances have consolidated nearly all generic purchasing into the hands of a few "mega-buyers," whose relentless pursuit of lower acquisition costs has pushed the generic manufacturing industry to the brink of collapse, creating a fragile and brittle supply chain that is the direct cause of chronic, systemic drug shortages.

The landscape of generic drug purchasing is dominated by a small number of these powerful sourcing consortia, which are joint ventures between the largest players in the supply chain:

- **Red Oak Sourcing:** A 50/50 joint venture established in 2014 between wholesaler Cardinal Health and CVS Health, which is both the largest retail pharmacy chain and a dominant PBM (CVS Caremark).³⁰
- **ClarusONE Sourcing Services:** A joint venture formed in 2016 between wholesaler McKesson Corporation and Walmart, the nation's largest retailer.³⁴
- **Walgreens Boots Alliance Development (WBAD):** A Swiss-based joint venture that serves as the global procurement arm for Walgreens. Crucially, through its long-term distribution agreement, wholesaler Cencora (AmerisourceBergen) sources its generic drugs through WBAD, effectively sharing in and contributing to its purchasing scale. The PBM Express Scripts also participates in WBAD through its generic purchasing arm Econdisc.⁹

The formation of these entities has radically concentrated purchasing power. By 2017-2018, it was estimated that these groups accounted for an astounding 90% of all generic drug purchases from manufacturers in the United States.⁸ This extreme consolidation of buy-side power has fundamentally altered the market dynamic. Generic manufacturers no longer sell into a fragmented market of thousands of pharmacies and hundreds of wholesalers. Instead, they face a handful of gatekeepers who control access to nearly the entire U.S. market.

This structure places the sourcing GPOs in the position of being price-setters and market-makers.³⁷ To secure a contract with Red Oak, ClarusONE, or WBAD is to gain access to a massive portion of the market; to fail to do so is to be effectively shut out.³⁸ This dynamic forces generic manufacturers into a brutal "race to the bottom," where they must compete

almost exclusively on offering the lowest possible price.⁸ The GPOs' negotiating leverage is so immense that they can extract prices that are often at or below the cost of production, severely threatening the profitability and long-term sustainability of the manufacturers. The consequences of this intense, artificially created price pressure are severe and predictable. First, it leads to market consolidation on the manufacturing side. Only the largest generic manufacturers, typically those with significant offshore production in India and China, have the scale to produce the massive volumes required to win a GPO contract and survive on razor-thin margins.⁹ Smaller manufacturers are driven out of the market. Second, it forces manufacturers to abandon the production of less profitable, older, but often medically essential generic drugs, particularly sterile injectables which are complex and costly to produce.³⁹ When prices are driven to unsustainable levels, manufacturers will logically exit those markets to focus on more profitable products.

This combination of manufacturer consolidation and market exit creates a dangerously fragile supply chain. The GPOs often move toward awarding single-source contracts to the manufacturer offering the lowest price.¹¹ This eliminates manufacturing redundancy. When that single, contracted manufacturer inevitably experiences a production delay, a quality control issue leading to an FDA shutdown, or a disruption in sourcing raw materials, there is no alternative supplier ready to step in. The result is an immediate and often prolonged drug shortage.⁴⁰

Therefore, the persistent shortages of chemotherapy drugs, antibiotics, and other critical medications are not an accident or a sign of isolated market failures. They are a direct, structural outcome of a purchasing system designed to maximize the leverage of intermediaries at the expense of the stability of the manufacturing base. The GPOs' business model prioritizes the lowest possible immediate acquisition cost above all other considerations, including supply chain resilience and redundancy. The public health consequences of this model have become so severe that in February 2024, the Federal Trade Commission (FTC) and the Department of Health and Human Services (HHS) issued a formal Request for Information to investigate how the contracting practices of GPOs and wholesalers are contributing directly to the generic drug shortage crisis.⁴² This federal inquiry validates the long-held concern that the monopsony power wielded by these sourcing alliances is a primary driver of instability in the nation's drug supply.

The table below clarifies the ownership and immense market control of these

dominant sourcing entities.

GPO Name	Controlling/Parent Entities
Red Oak Sourcing	Cardinal Health, CVS Health
ClarusONE Sourcing Services	McKesson Corporation, Walmart
Walgreens Boots Alliance Development (WBAD)	Walgreens, Cencora (AmerisourceBergen), Econdisc (Express Scripts, Kroger)

Data compiled from sources.⁸

This visualization of consolidated power makes it clear that the generic drug market is not a free market. It is a market managed and controlled by a few powerful buyers whose practices, while beneficial to their own bottom lines, have systematically eroded the manufacturing base and created the conditions for the ongoing public health crisis of drug shortages.

The Price Paradox: Squeezing Manufacturers, Inflating Pharmacy Costs

The market power of the Big Three wholesalers manifests in a central paradox that defines the economics of the generic drug supply chain: they have constructed a system that allows them to simultaneously pay manufacturers less for generic drugs while charging their pharmacy customers more. This is not a contradiction but the core of their business model for generics, which has evolved from simple distribution to a form of market arbitrage. By acting as a powerful monopsony on the purchasing side and a restrictive oligopoly on the selling side, wholesalers create and exploit an artificial price spread, capturing enormous profits at the expense of both manufacturers and pharmacies.

The first half of this paradox—the squeeze on manufacturers—is executed through the generic sourcing GPOs like Red Oak and ClarusONE, as detailed in the previous section. By consolidating over 90% of the purchasing volume, these entities force generic manufacturers into a hyper-competitive, price-driven "race to the bottom".⁹ This intense downward pressure drives the wholesalers' acquisition cost for generics to the lowest possible level, often to a point that is financially unsustainable for the manufacturers themselves.¹¹

The second half of the paradox—inflating costs for pharmacies—is where the wholesalers' oligopoly power comes into play. Having acquired generic drugs at deeply discounted prices, they do not pass these savings down the supply chain. Instead, they sell these same drugs to pharmacies at a significant markup.⁴³

The ability to sustain such high markups in a supposedly competitive product category is directly enabled by the anticompetitive contracting mechanisms imposed on pharmacies, most notably the Generic Compliance Ratios (GCRs). As established in Section III, GCRs effectively trap pharmacies into sourcing the vast majority of their generics from their primary wholesaler. A pharmacy that attempts to buy a cheaper generic from a secondary supplier risks losing tens of thousands of dollars in rebates on its entire portfolio of drug purchases.⁴⁴ This contractual coercion eliminates the threat of price competition from secondary wholesalers and creates a captive market. Pharmacies are forced to accept the primary wholesaler's inflated generic prices as a condition of maintaining access to essential brand-name drugs and the rebate structures necessary for their financial survival.³

Ultimately, the wholesalers have engineered a two-sided market where they control the pricing dynamics on both ends. They have moved beyond a simple logistics model, where profit is earned for the service of distribution, to an arbitrage model, where profit is extracted from a price differential that they themselves create and maintain through market power. They use their GPOs to create an artificial price floor with manufacturers (monopsony power) and use their GCR-based contracts to create an artificial price ceiling with pharmacies (oligopoly power). The vast space between that floor and ceiling is the wholesaler's arbitrage profit—a profit not of value created, but of value extracted from a controlled and manipulated market. The 19% markup on generics is the statistical signature of this arbitrage model in action, a clear indicator of a market that is not functioning competitively.

Coercive Contracting: Weaponizing "Failure to Supply" and "Right of First Refusal" Clauses

The market power of the Big Three pharmaceutical wholesalers is codified and enforced through highly specific and often punitive clauses within their contracts with both manufacturers and pharmacy customers. Two such provisions, "Failure to Supply" (FTS) and "Right of First Refusal" (ROFR) clauses, stand out as particularly potent instruments of market

discipline. While framed as standard business protections, these clauses are weaponized by the wholesalers to reinforce their dominant position. FTS clauses are used to discipline the supply side—the generic manufacturers—ensuring their compliance with the low-price regime dictated by the sourcing GPOs. Simultaneously, ROFR clauses are used to discipline the demand side—pharmacies and potential competitors—preventing any deviation from the wholesalers' high-price regime. Together, they form a contractual pincer movement that squeezes manufacturers and boxes out competition.

Failure to Supply (FTS) Clauses

A Failure to Supply clause is a contractual provision that defines the consequences if a supplier cannot deliver goods as agreed upon in a purchase order or contract.⁴⁹ In a normal commercial relationship, this is a reasonable protection for the buyer against supply disruptions. However, in the context of the U.S. generic drug market, these clauses become abusive. As established, the wholesaler-led GPOs exert immense monopsony power to force generic manufacturers to accept unsustainably low prices, often at or below the cost of production.⁸ The FTS clause is then imposed on top of this coerced low price.

The practical effect is that a generic manufacturer is contractually obligated to supply whatever volume the wholesaler demands at a price that may be unprofitable, and if it fails to do so—perhaps due to the very production line fragility caused by those low margins—it is then hit with significant financial penalties.¹¹ This creates an untenable "death spiral" for the manufacturer. It can either continue to produce at a loss to meet its contractual obligations and avoid FTS penalties, or it can be forced to exit the market for that product entirely. This dynamic has been identified by industry groups and government agencies as a key contributor to drug shortages. The economic pressure created by the combination of artificially low prices and punitive FTS penalties disincentivizes investment in manufacturing quality and redundancy, making the supply chain brittle and prone to failure.¹¹ The erosion of reasonable FTS clauses, which once may have accounted for legitimate manufacturing challenges, and their replacement with rigid, punitive versions is now seen as a direct cause of market instability.⁴⁰

Right of First Refusal (ROFR) Clauses

While FTS clauses control manufacturers, Right of First Refusal clauses control pharmacies and neutralize competitors. A ROFR is a contractual right that requires a party (in this case, a pharmacy) that receives a third-party offer for a good or service to first offer the deal to the holder of the right (the primary wholesaler) on the same terms.⁵⁰ In their PVAs with pharmacies, the Big Three wholesalers frequently extract ROFRs on the products they distribute.¹⁴

This clause functions as a powerful anticompetitive tool. It allows the incumbent wholesaler to maintain high prices across its network of pharmacies without fear of being undercut. A smaller, more efficient secondary wholesaler might invest significant resources in identifying an opportunity to offer a pharmacy a better price on a portfolio of generic drugs. However, because of the ROFR, the pharmacy cannot simply accept this better offer. It must first present the competitor's offer to its primary Big Three wholesaler. The incumbent can then simply decide to match the price and retain the business.¹⁴

This practice has a profound chilling effect on competition. It disincentivizes secondary wholesalers from even attempting to compete for a pharmacy's business. Their competitive efforts and pricing strategies are, in effect, turned into free market research for the incumbent, who can sit back, maintain its high-margin pricing structure, and only offer targeted discounts defensively when a competitor makes a move. The secondary wholesaler does all the work of demonstrating a lower market price is possible, only to have the incumbent swoop in and capture the benefit. This allows the Big Three to avoid proactive, market-wide price competition, preserving their overall profitability while selectively eliminating competitive threats as they arise.¹⁴ Hercules Pharmaceuticals, a secondary wholesaler, has specifically cited the use of ROFRs by the Big Three as a direct cause for being denied a significant amount of business, highlighting the substantial harm these clauses inflict on market competition.¹⁴

In synthesis, these two contractual weapons work in tandem to protect the wholesaler's artificially inflated generic drug margins. The FTS clause ensures a steady supply of low-cost generics from manufacturers who are contractually bound to produce, even at a loss. The ROFR clause ensures a steady, captive customer base of pharmacies who are contractually prevented from effectively accessing lower prices from competitors. This contractual architecture locks in the price spread from which the wholesalers profit,

reinforcing the stability of the oligopoly and the fragility of the broader supply chain.

The Power of the Float: Financial Engineering in the Supply Chain

Beyond the direct profits generated from marking up drug prices, the Big Three wholesalers have engineered a secondary, yet immensely powerful, revenue stream derived from the manipulation of payment cycles within the supply chain. This practice is centered on the concept of "float," the temporary pool of capital a company holds after receiving payment from its customers but before it has to pay its own suppliers. By strategically managing their cash conversion cycle—adhering to the mantra to "collect early, and pay late"¹⁵—wholesalers force other, weaker participants in the supply chain to provide them with billions of dollars in interest-free working capital, which they then invest for their own financial gain.

The Cash Conversion Cycle (CCC) is a key metric of operational and financial efficiency. It measures the number of days it takes for a company to convert its investments in inventory and other resources into cash flow from sales. The formula is $CCC = DIO + DSO - DPO$, where DIO is Days Inventory Outstanding, DSO is Days Sales Outstanding, and DPO is Days Payable Outstanding.⁵² A company's goal is to minimize its CCC, as a shorter cycle indicates greater liquidity and less reliance on external financing. A negative CCC is the most desirable state, meaning a company is paid by its customers before it has to pay its suppliers. The Big Three wholesalers have masterfully engineered their business operations to achieve an exceptionally favorable CCC, leveraging their market power over both their customers (pharmacies) and their suppliers (manufacturers).

1. **Minimizing Days Sales Outstanding (DSO):** The DSO component measures how quickly a company collects payment after a sale. Wholesalers impose strict and often short payment terms on their pharmacy customers.⁵⁴ This is particularly burdensome for independent pharmacies, which often face their own cash flow challenges due to the long and unpredictable reimbursement cycles from PBMs.⁵⁵ While a pharmacy may have to wait 30 to 60 days to be reimbursed for a dispensed prescription, its wholesaler typically demands payment on a much shorter timeline. This power dynamic allows the wholesaler to minimize its DSO, collecting cash from pharmacies quickly.
2. **Maximizing Days Payable Outstanding (DPO):** The DPO component measures how long a company takes to pay its own bills. Here, wholesalers use their leverage over

pharmaceutical manufacturers. As the primary gatekeepers to the U.S. market, they are able to negotiate extended payment terms for themselves.⁵⁶ A manufacturer, dependent on the wholesaler for distribution, has little choice but to accept these terms. This allows the wholesaler to maximize its DPO, holding onto its cash for as long as possible before paying its suppliers.

The combination of a very low DSO and a very high DPO results in a negative or near-zero CCC for the wholesalers. This means they consistently hold a massive pool of cash—the float—that belongs, in an operational sense, to other entities. They are, in effect, receiving a continuous, interest-free loan from the entire supply chain. This float capital does not sit idle; it is invested in short-term financial instruments, generating substantial interest income for the wholesalers. This profit is not derived from the core business of distributing drugs but from a sophisticated form of financial engineering made possible entirely by their market dominance.¹⁶

This practice represents a significant transfer of wealth and financial stability from the more vulnerable parts of the supply chain to the most powerful. Independent pharmacies, already squeezed on reimbursement and acquisition costs, are forced to act as a source of rapid cash flow for their largest supplier. Generic manufacturers, already operating on razor-thin margins due to GPO price pressure, are forced to wait for payment, effectively providing zero-interest financing to their largest customer. This financial extraction exacerbates the precarity of pharmacies and manufacturers, making them more susceptible to financial distress, while simultaneously bolstering the balance sheets and profitability of the wholesalers. The power of the float is a clear example of how the oligopoly's control extends beyond pricing and terms into the fundamental financial mechanics of the entire healthcare sector.

The Surveillance State: Pharmacy Switches as an Enforcement Mechanism

The contractual power of the Big Three wholesalers, particularly their ability to enforce restrictive terms like Generic Compliance Ratios (GCRs), is underpinned by a little-known but critically important layer of the healthcare data infrastructure: the pharmacy switch. The vertical integration of the dominant supply chain players into the ownership of these switches

has transformed what should be neutral data conduits into a proprietary surveillance and enforcement system. This system provides wholesalers with a perfect, real-time view into the operations of their pharmacy customers, eliminating information asymmetry and making deviation from their coercive contracts nearly impossible to conceal.

A pharmacy switch acts as the central "traffic cop" or router for prescription drug claims.¹⁷ When a pharmacist fills a prescription and submits a claim for reimbursement, the pharmacy's software sends the claim to a switch. The switch then uses information on the patient's insurance card, such as the Bank Identification Number (BIN) and Processor Control Number (PCN), to route the claim instantaneously to the correct Pharmacy Benefit Manager (PBM) for adjudication. The PBM's response—approving or denying the claim and specifying the patient's copay and the pharmacy's reimbursement—is routed back through the switch to the pharmacy, all within a matter of seconds.¹⁷ This near-instantaneous data exchange is the backbone of the modern retail pharmacy system.

The critical issue arises from the ownership of this infrastructure. The market for pharmacy switch services is, like the wholesale market, a highly concentrated duopoly. The two dominant players are:

- **Relay Health:** Owned by McKesson, one of the Big Three wholesalers, since 2006.¹⁷
- **Change Healthcare:** Acquired by UnitedHealth Group (UHG) in 2022, making it a sister company to OptumRx, one of the three largest PBMs in the country.¹⁷

This vertical integration is profoundly significant. It means that the very entities that write and benefit from restrictive pharmacy contracts also own the infrastructure that processes the data revealing compliance with those contracts. Because nearly every prescription claim flows through one of these two switches, their owners have access to a complete, real-time firehose of data on every single drug dispensed by thousands of pharmacies across the country. This data includes the specific drug (NDC number), quantity, dispensing date, patient information, and reimbursement details.¹⁹

Wholesalers weaponize this data access to enforce their contracts. The core mechanism is the comparison of two data sets: the "purchase data" from the wholesaler's own sales records and the "dispense data" from the switch. A wholesaler like McKesson can precisely monitor a pharmacy's compliance with its GCR by reconciling these two streams of information.¹⁸ For example, a wholesaler's contract may have a Generic Purchasing Ratio (GPR) provision, which explicitly compares the generic items a pharmacy purchases from the

wholesaler versus the generic items it dispenses, with the discrepancy being read through switch data.¹⁸ If the switch data shows a pharmacy dispensed 1,000 tablets of a generic atorvastatin in a month, but the wholesaler's sales data shows the pharmacy only purchased 800 tablets from them, the wholesaler has incontrovertible proof that the pharmacy sourced 200 tablets from a secondary supplier. This constitutes a breach of the GCR/GPR, triggering contractual penalties such as the clawback of rebates or the imposition of less favorable pricing on brand-name drugs.

The National Community Pharmacists Association (NCPA) raised exactly these concerns in its vehement opposition to the UHG acquisition of Change Healthcare. The NCPA warned the Department of Justice that the merger would give UHG "a trove of intelligence on its smaller competitors" and that this data "will be used to undercut reimbursements and raise fees on independent pharmacies" and steer patients to UHG's own mail-order pharmacy.⁵⁸ This fear is rooted in the reality that switch data provides a panoptic view of a pharmacy's business, which can be used to gain an unfair competitive advantage and enforce punitive contract terms.

Ultimately, the ownership of switches by dominant wholesalers and PBMs represents the capstone of their system of control. It transforms a piece of essential market infrastructure into an instrument of surveillance. The threat of non-compliance with a GCR is no longer a matter of facing a potential, periodic manual audit; it is a certainty of being caught by an automated, data-driven system in real-time. This constant monitoring creates a powerful deterrent that ensures pharmacy adherence to the wholesaler's anticompetitive contracts, cementing their market power and making it virtually impossible for independent pharmacies to escape their grasp.

Conclusion: An Interlocking System of Control and a Call for Systemic Reform

The analysis presented in this report demonstrates that the price inflation, market foreclosure, and supply chain fragility endemic to the U.S. pharmaceutical market are not the result of disparate market failures. Rather, they are the calculated outcomes of a cohesive and interlocking system of control, architected and operated by the Big Three pharmaceutical wholesalers—Cencora, Cardinal Health, and McKesson. Through a sophisticated combination

of anticompetitive contracting, strategic vertical integration, and the exploitation of engineered monopsony power, this oligopoly has effectively captured the pharmaceutical supply chain, enabling it to extract immense value at the expense of manufacturers, pharmacies, and patients.

The seven mechanisms detailed in this report do not operate in isolation; they are synergistic and mutually reinforcing. The system begins with the wholesaler-owned **PSAOs**, which channel thousands of independent pharmacies into **Prime Vendor Agreements**. These agreements contain punitive **Generic Compliance Ratios**, which function as tying arrangements that leverage the wholesalers' monopoly on brand drugs to force purchases of high-margin generics, effectively locking out competition from secondary suppliers. This captive market allows the wholesalers to engage in a price paradox: on one side, their **generic sourcing GPOs** (Red Oak, ClarusOne, WBAD) wield immense monopsony power to drive manufacturer prices to unsustainable levels, creating the very supply fragility that leads to drug shortages

This system is reinforced by coercive contractual weapons. **"Failure to Supply" clauses** discipline manufacturers who cannot meet demand at these artificially low prices, while **"Right of First Refusal" clauses** neutralize any competitive threat from secondary wholesalers who dare to offer pharmacies a better price. The entire structure is lubricated by the financial engineering of **"float" capital**, where the wholesalers' favorable cash conversion cycle forces pharmacies and manufacturers to provide them with billions in interest-free working capital. Finally, the entire edifice is monitored and enforced by the wholesalers' ownership of the primary **pharmacy switches**, which have been converted from neutral infrastructure into a panoptic surveillance system for ensuring perfect compliance with their restrictive contracts.

This is a closed loop, a system designed for control and value extraction at every node. It is a system that rewards consolidation and punishes competition, prioritizes intermediary profit over manufacturing stability, and transfers wealth from the most vulnerable participants—independent pharmacies and generic manufacturers—to the most powerful. The chronic drug shortages and unaffordable prices that plague the American healthcare system are the logical and inevitable consequences of this market structure.

Section 12: PBMs and Wholesalers: Colluding for Control

Introduction: The Architecture of an Opaque Market

While legislative scrutiny often focuses on the pricing distortions of pharmaceutical benefit managers, we posit that the relationship between Pharmacy Benefit Managers (PBMs) and pharmaceutical wholesalers is an often ignored but critical factor in maintaining high drug costs. The central thesis of this analysis is that these two sectors, far from being independent actors in a competitive marketplace, have evolved into a functional oligopoly. Their business models are deeply intertwined, their financial incentives are powerfully aligned, and their strategic alliances create a system that systematically inflates drug costs, stifles competition, and inflicts significant harm upon patients, payers, and independent healthcare providers. This report will deconstruct this complex relationship, revealing an architecture of control built upon shared interests in opaque pricing, consolidated market power, and the strategic marginalization of competitors.

Establishing the Oligopoly

As previously discussed in prior sections, the power wielded by these intermediaries is magnified by extreme market concentration. Both the wholesaling and PBM sectors are dominated by a small handful of colossal entities, creating a parallel oligopolistic structure that is foundational to the issues explored in this report. To briefly review:

Wholesaler Market Concentration: The U.S. drug distribution market is one of the most concentrated sectors in the American economy. The "Big Three" wholesalers—Cencora, Cardinal Health, and McKesson—collectively control over 90% of the market, with some estimates placing their combined share as high as 95%.¹⁰ This dominance makes them indispensable partners for both manufacturers seeking to bring drugs to market and pharmacies needing to stock their shelves. Their combined U.S. drug distribution revenues were projected to reach a staggering \$700 billion in 2023, underscoring the immense scale of

their operations.¹²

PBM Market Concentration: The PBM market mirrors this concentration. The "Big Three" PBMs—CVS Caremark (a subsidiary of CVS Health), Express Scripts (a subsidiary of Cigna), and OptumRx (a subsidiary of UnitedHealth Group)—are estimated to process nearly 80% of all prescription claims in the United States.¹³ This consolidation gives them unparalleled leverage in negotiations with drug manufacturers and pharmacies. In many states, the top PBM holds a market share of at least 40-50%, creating a local monopsony where pharmacies have no meaningful alternative but to accept the PBM's contract terms.¹⁵

This parallel concentration is not a coincidence but rather the structural foundation upon which a collusive environment has been built. The public narrative often presents a false dichotomy, portraying wholesalers as mere logistical players—a "dumb pipe" for physical products—while PBMs are seen as the sophisticated financial "smart controllers" of the system.⁵ This report will demonstrate that this distinction is fundamentally misleading. Wholesalers, through their direct financial interest in drug pricing, their ownership of Pharmacy Services Administrative Organizations (PSAOs) that negotiate financial terms with PBMs, and their role as "price-setters and market-makers for generic drugs," are deeply engaged financial actors.¹⁶ Their strategies are not just compatible with those of the PBMs; they are synergistically aligned to maximize mutual profit. Through shared financial incentives tied to opaque pricing benchmarks, deeply integrated business ventures, and the strategic manipulation of pharmacy networks, PBMs and wholesalers have created an environment that prioritizes their own revenue over system-wide cost savings, effectively controlling the pharmaceutical market to the detriment of payers, patients, and the very fabric of community pharmacy.

The WAC-Based Pricing System: A Foundation for Mutual Profit

At the heart of the symbiotic relationship between PBMs and pharmaceutical wholesalers lies a fundamental economic mechanism that aligns their financial interests: a drug pricing system built upon the foundation of an artificially inflated and opaque benchmark known as the Wholesale Acquisition Cost (WAC). While seemingly a simple list price, the WAC and its derivatives serve as the linchpin for the revenue models of both types of intermediaries. Because both PBMs and wholesalers derive significant portions of their

revenue from fees and rebates calculated as a percentage of this inflated starting price, they share a powerful, deeply entrenched incentive to perpetuate a system where high list prices are not a problem to be solved but a prerequisite for profitability. This shared incentive fosters an environment where the actual cost of a drug becomes secondary to the preservation of a pricing structure that maximizes intermediary revenue.

Deconstructing Inflated Price Benchmarks

The language of pharmaceutical pricing is a confusing lexicon of acronyms, but two benchmarks are central to understanding the system's inflationary dynamics: the Wholesale Acquisition Cost (WAC) and the Average Wholesale Price (AWP).

Wholesale Acquisition Cost (WAC): The WAC is formally defined as the manufacturer's list price for a drug to wholesalers or other direct purchasers *before* any discounts, rebates, allowances, or other price concessions are applied.¹⁸ It is the initial "list price" that a manufacturer establishes for its product and reports to pricing compendia like First Databank and Medi-Span.¹⁸ The critical feature of the WAC is that it does not represent an actual transaction price; it is a starting point for negotiations, a sticker price from which all subsequent discounts and rebates are calculated.²⁰

Average Wholesale Price (AWP): The AWP is an even more controversial benchmark, often referred to as the "sticker price" of a prescription drug.²² It is not a true average of any actual prices paid by anyone in the supply chain. Instead, AWP is a calculated figure, typically derived by applying a standard 20% markup to the WAC (i.e., $AWP=WAC \times 1.2$).²² For decades, PBM contracts with health plans and pharmacies have been structured around AWP, promising a specified discount off this inflated number (e.g., reimbursement at "AWP minus 18%").²³ Because the AWP is a purely theoretical number based on another list price, it is easily manipulated and has been widely criticized for being an inaccurate and inflationary benchmark that serves primarily to make negotiated discounts appear larger than they actually are.²²

The Wholesaler Revenue Model: Fee-for-Service on an Inflated Base

While wholesalers portray their business as a high-volume, low-margin logistics operation,

their revenue model is directly and favorably linked to high drug list prices.⁵ Wholesalers primarily generate revenue through fee-for-service agreements with pharmaceutical manufacturers.⁵ These fees cover a range of services, including distribution, inventory management, data reporting, and bearing financial risk.

Crucially, these service fees are not typically flat dollar amounts per unit. Instead, they are very often calculated as a percentage of the drug's WAC.²⁵ This structural link creates a clear and direct financial incentive for wholesalers to support a high-WAC pricing system. For every dollar that a manufacturer increases a drug's WAC, the wholesaler's fee-for-service revenue on that drug also increases. A wholesaler distributing a \$1,000 drug with a 2% distribution fee earns \$20, while distributing a \$100 drug with the same fee earns only \$2, even if there is no increased cost involved in the distribution of the more expensive product. Consequently, wholesalers are financially rewarded for distributing higher-priced drugs and for price inflation across the board. This model ensures that their interests are aligned not with cost containment, but with the maintenance of the highest possible list prices set by manufacturers.

The PBM Revenue Model: The Rebate Game and Spread Pricing

As we have previously reviewed at length, the PBM revenue model is more complex but is similarly, and even more powerfully, tethered to high list prices. The reliance on WAC and AWP is not merely an industry convention; it functions as a powerful mechanism for tacit collusion. It establishes a shared incentive structure where both PBMs and wholesalers profit from the same action—the maintenance and inflation of list prices—without needing to engage in explicit coordination. The wholesaler's revenue from distribution fees increases with a higher WAC.²⁵ The PBM's revenue from retained rebates and price spreads also increases with a higher WAC/AWP.²⁶ When both dominant intermediary sectors act in their own rational self-interest, their behavior is naturally and systematically aligned toward an anti-competitive outcome that harms payers and patients. The pricing benchmark itself coordinates their actions, creating a system that is inherently inflationary.

This dynamic creates what can be termed the "gross-to-net bubble"—the vast and growing gap between a drug's initial list price and its final net price after all rebates and discounts are paid.³⁰ This bubble of money is precisely where intermediaries extract their

profits. By framing the public debate as a conflict between manufacturers' high list prices and PBMs' negotiated net price "savings," the intermediaries cleverly obscure the fact that their own profitability depends on the *size of the bubble itself*. A larger bubble, created by a higher starting list price, provides a larger pool of funds from which both wholesalers (on the gross side) and PBMs (in the spread) can draw their revenue. The entire system is therefore incentivized to inflate the starting point to maximize the intermediary profits captured within this gross-to-net gap.

Entangled Operations: Joint Ventures and Vertical Integration

Beyond the shared financial incentives created by the WAC-based pricing system, the relationship between PBMs and wholesalers is solidified through a web of concrete operational and structural ties. These are not arm's-length, transactional business relationships. They are deep, strategic partnerships and integrations that serve to consolidate market control, reduce transparency, create formidable barriers to entry for potential competitors, and align the entities' day-to-day operations. This entanglement manifests in three critical areas: generic drug sourcing, shared control of essential data infrastructure, and the closed-loop ecosystem of specialty pharmaceuticals. These interlocking ventures demonstrate a coordinated strategy to dominate key segments of the supply chain.

Generic Sourcing Consortia: Controlling the Supply

One of the most powerful and least understood areas of PBM-wholesaler collaboration is in the procurement of generic drugs through massive generic Group Purchasing Organizations (GPOs), also known as "source programs," and joint ventures. These entities aggregate the purchasing volume of their parent companies, creating buying power on a scale that dwarfs any other player in the market. This consolidation effectively makes them the primary gatekeepers to the U.S. generic drug market.

These ventures create a horizontal consolidation of power that has profound market implications. While proponents argue they can achieve greater efficiency and negotiate lower acquisition costs from generic manufacturers, their immense power also allows them to exert immense pressure on those manufacturers.³² They can effectively decide which

manufacturers gain access to a vast portion of the U.S. market, potentially excluding smaller competitors or favoring the products of certain manufacturers over others. This gatekeeper function reduces competition at the manufacturing level and centralizes control over generic supply and pricing within the PBM-wholesaler oligopoly.¹⁶

Shared Infrastructure and Data Control: The Case of Surescripts

Control over the physical and financial flows of pharmaceuticals is reinforced by control over the flow of data. The most prominent example of this is Surescripts, the health information technology company that operates the dominant electronic prescribing network in the United States.³³ However, the pharmacy “switches,” which route prescriptions claims for adjudication, are another important example.

Surescripts is the digital backbone of the prescription market, handling the routing of electronic prescriptions from physicians to pharmacies and verifying patient eligibility and benefits for the vast majority of transactions. The ownership structure of Surescripts has long been a source of significant antitrust concern, as it represents a joint venture between would-be competitors. Surescripts is co-owned by two of the largest PBMs, CVS Caremark and Express Scripts, and two major pharmacy trade associations, the National Association of Chain Drug Stores and the National Community Pharmacists Association.³³ This places control over the nation’s critical e-prescribing infrastructure directly in the hands of the dominant market incumbents.

The Federal Trade Commission (FTC) filed a complaint against Surescripts, alleging that the company engaged in a long-running anticompetitive scheme to illegally maintain its monopoly power.³³ The FTC alleged that Surescripts used loyalty pricing and other contractual restrictions to demand exclusivity from its customers, effectively foreclosing the market and preventing competitors from gaining a foothold.³³ By controlling this essential infrastructure, the incumbent PBMs and their allies can monitor market activity, stifle the growth of competitors who require access to the network to operate, and, critically, control the development and deployment of tools that could bring true price transparency to the point of care. This control over the data “choke point” ensures that any innovations in price transparency do not fundamentally threaten the opaque, rebate-driven business model that is so profitable for its owners.³⁴

The Specialty Drug Ecosystem: A Closed Loop of Profit

The specialty drug market—comprising high-cost medications for complex conditions like cancer, rheumatoid arthritis, and multiple sclerosis—is the most lucrative and fastest-growing segment of the pharmaceutical industry.¹⁵ It is also where the vertical integration between PBMs and wholesalers is most pronounced and profitable.

The dominant PBMs have aggressively moved to control this market by acquiring or building their own specialty pharmacies.³⁶ Through mergers, acquisitions, and organic growth, pharmacies affiliated with the “Big Three” PBMs now account for nearly 70% of all specialty drug revenue in the U.S.¹⁵ PBMs then design insurance benefits that steer or mandate that patients use these “captive” specialty pharmacies to fill their prescriptions.⁹

This vertical integration downstream is complemented by a critical partnership upstream. These massive, PBM-owned specialty pharmacies become the largest and most important customers for specialty drug distributors. These distributors are often specialized subsidiaries of the “Big Three” full-line wholesalers, such as Cencora or McKesson.³⁷ This creates a highly profitable, self-reinforcing, and closed loop:

1. A PBM negotiates rebates on a high-cost specialty drug.
2. The PBM designs its formulary to steer patients requiring that drug exclusively to its own specialty pharmacy.
3. The PBM-owned specialty pharmacy then purchases the drug from a specialty distributor owned by or partnered with one of the major wholesalers.

This structure represents a sophisticated strategy of market foreclosure. The combination of horizontal collusion (in generic sourcing) and vertical integration (in specialty drugs and data infrastructure) creates a fortress that is nearly impossible for new, independent players to penetrate. An independent specialty pharmacy cannot effectively compete because the PBMs control patient access and will steer them away. A new specialty distributor cannot gain scale because the largest customers—the PBM-owned pharmacies—are locked into preferential relationships with the incumbent wholesalers. This multi-pronged strategy ensures that control over the most profitable segments of the pharmaceutical market remains firmly in the hands of the established oligopoly.

The PSAO Paradox: Representation or Coercion?

For the tens of thousands of independent pharmacies across the United States, navigating the complex and often hostile landscape of PBM contracting is an existential challenge. To level the playing field, the vast majority of these pharmacies have turned to Pharmacy Services Administrative Organizations (PSAOs), entities designed to act as collective bargaining agents on their behalf. In theory, PSAOs amplify the voices of small businesses, allowing them to negotiate with the powerful PBM oligopoly from a position of strength. However, the reality of the PSAO market presents a profound paradox. The widespread ownership of the largest and most influential PSAOs by the "Big Three" pharmaceutical wholesalers creates an irreconcilable conflict of interest. This chapter will argue that this ownership structure transforms many PSAOs from genuine advocates for pharmacies into instruments of coercion that ultimately serve to align independent pharmacies with the strategic and financial goals of the broader PBM-wholesaler oligopoly.

The Stated Purpose of PSAOs

PSAOs are intermediary service organizations that provide a suite of administrative and contracting services to independent and small-chain pharmacies.³⁸ An estimated 83% of all independent pharmacies in the U.S. contract with a PSAO, making them a near-ubiquitous feature of the community pharmacy landscape.⁴⁰ The primary and most critical function of a PSAO is to collectively negotiate contracts with PBMs on behalf of its network of member pharmacies.⁴¹ These negotiations cover the essential terms that determine a pharmacy's financial viability, including:

- **Reimbursement Rates:** The amount a pharmacy is paid for the ingredient cost of a dispensed drug.
- **Dispensing Fees:** The professional fee paid to the pharmacy for the service of dispensing.
- **Network Participation:** Gaining entry into a PBM's pharmacy network, which is essential for accessing insured patients.
- **Contract Terms:** Complex clauses related to payment frequency, audit procedures, and performance metrics.⁴¹

Beyond contract negotiation, PSAOs provide a range of "back-office" support services, such as claims reconciliation, credentialing assistance, and compliance support, which are intended to create administrative efficiencies and allow pharmacists to focus on patient care.⁵ For these services, pharmacies typically pay the PSAO a flat monthly fee.³⁸

The Reality of Wholesaler Ownership

While the services provided by PSAOs are ostensibly for the benefit of pharmacies, the ownership of these organizations reveals a different set of interests. The PSAO market is dominated by the same entities that dominate the drug distribution market. The largest and most powerful PSAOs are subsidiaries of the "Big Three" wholesalers¹⁷:

- **Health Mart Atlas** is owned by McKesson.
- **Elevate Provider Network** is owned by AmerisourceBergen (Cencora).
- **LeaderNET** is one of three PSAOs operated by Cardinal Health.⁴⁵

Collectively, over 75% of independent pharmacies that use a PSAO are members of an organization owned by one of these three wholesalers.⁴¹ This consolidation of power means that the entity negotiating on behalf of a pharmacy with a PBM is owned by the pharmacy's primary drug supplier. This relationship is not always optional. A landmark 2013 Government Accountability Office (GAO) report on PSAOs found that some wholesaler-owned PSAOs explicitly required their member pharmacies to also be customers of their drug distribution business, creating a "tied" arrangement that locks pharmacies into using the wholesaler's services.⁴⁷

The Inherent Conflict of Interest

The ownership of PSAOs by wholesalers creates a fundamental and irreconcilable conflict of interest that undermines the PSAO's ability to act as a true fiduciary for its pharmacy members. The financial incentives of the PSAO's parent company (the wholesaler) are not aligned with the financial interests of its pharmacy clients; in many respects, they are more closely aligned with the PBMs on the other side of the negotiating table.

Consider the incentive structure. As established above, both wholesalers and PBMs benefit from a pricing system based on high, inflated WACs. Wholesalers earn

percentage-based fees on WAC, and PBMs earn percentage-based rebates on WAC. Furthermore, as also detailed above, wholesalers and PBMs are often partners in massive generic sourcing joint ventures like Red Oak Sourcing.³² The big PBMs run the country's largest mail order and specialty pharmacies, and are large and profitable customers to the wholesalers. These deep financial and operational ties mean that a wholesaler has a vested interest in maintaining a stable, profitable, and non-adversarial relationship with the major PBMs.

This places the wholesaler-owned PSAO in an impossible position. Its stated mission is to negotiate aggressively against PBMs to secure the best possible reimbursement terms for its pharmacy members. However, if it negotiates too aggressively—if it demands reimbursement rates that significantly cut into PBM profit margins or challenges the opaque terms that benefit PBMs—it risks jeopardizing the far larger and more lucrative business relationships between its parent company and those same PBMs. The potential profit a wholesaler might forgo by angering a major PBM partner far outweighs the modest monthly fees it collects from its PSAO members. Consequently, there is a powerful incentive for the wholesaler-owned PSAO to accept unfavorable, take-it-or-leave-it contracts from PBMs—contracts that may be financially damaging to its pharmacy clients but are acceptable because they do not disrupt the profitable status quo of the wholesaler-PBM relationship.⁴⁴ The PSAO's ultimate loyalty is to its owner's bottom line, not to the financial health of the independent pharmacies it claims to represent.

This dynamic transforms the negotiation process into a performance of "controlled opposition." The existence of wholesaler-owned PSAOs creates the illusion of a fair, competitive negotiation, allowing the system to claim that independent pharmacies have robust representation. In reality, the entity at the negotiating table often has financial incentives that are fundamentally aligned with its supposed adversary. This structure ensures that while pharmacies get access to networks, the terms of that access are dictated by the needs of the PBM-wholesaler oligopoly, not the needs of community pharmacy.

Furthermore, by marketing PSAO services as a "value-added service," wholesalers obscure their function as a powerful lever of control.⁴⁸ By bundling the essential service of PBM network access with the essential service of drug supply, wholesalers create immense dependency and high switching costs for their pharmacy customers. A pharmacy cannot easily fire its PSAO without disrupting its relationship with its primary drug supplier, and vice

versa. This dependency gives the wholesaler-PSAO enormous leverage to push through PBM contracts that pharmacies might otherwise reject, solidifying the wholesaler's control over both the pharmacies' supply chain and their revenue streams.

The Squeeze on Main Street: Profiting from Pharmacy Distress

The collusive structure maintained by PBMs and wholesalers is not a victimless system. Its primary casualties are the nation's retail pharmacies, particularly the independent community pharmacies that serve as vital healthcare access points in countless urban and rural areas. PBMs have developed a sophisticated arsenal of financial mechanisms designed to extract maximum value from pharmacies, pushing many to the brink of financial collapse. These mechanisms, often cloaked in complex and opaque terminology, are not merely profitable for PBMs; they function as a strategic tool to weaken and eliminate independent competition. This, in turn, funnels more prescription volume and profit into the PBMs' own vertically integrated or "captive" pharmacy channels, fulfilling a strategic objective of market consolidation.

The Anatomy of PBM Fees

The financial pressure exerted on pharmacies is multifaceted, operating through a variety of fees, clawbacks, and reimbursement manipulations. While PBMs claim these are tools to ensure quality and control costs, in practice they function as unpredictable, post-transaction revenue extractors.

Fee Type	Purported Purpose	Typical Calculation Basis	Timing	Transparency Level	Data Source(s)
DIR Fees	Performance incentives; Reconcile negotiated vs. actual costs	Percentage of drug price (based on WAC/AWP) or a flat dollar amount per claim.	Retroactive (weeks or months after dispensing)	Opaque; formulas are proprietary and unpredictable.	⁴⁹
Network	To grant	Flat fee per	Often	Opaque; often	⁵¹

Participation Fees	pharmacy access to the PBM's network of patients.	claim, flat percentage of reimbursement, or periodic lump sum.	retroactive or reconciled periodically.	bundled into complex contracts.	
Audit Fees / "Clawbacks"	To ensure pharmacy compliance with contract terms and prevent fraud.	Penalties assessed for minor, often unavoidable, clerical errors found during audits.	Retroactive; clawed back from future payments.	Opaque; audit standards can be arbitrary.	⁴¹
Performance Adjustments	To incentivize quality care (e.g., medication adherence).	Based on metrics that may be irrelevant to the pharmacy's patient population or are statistically unattainable.	Retroactive; applied as penalties or reductions in payment.	Opaque; metrics and benchmarks are set solely by the PBM.	⁵⁰

Table 2: A Taxonomy of PBM Fees Imposed on Pharmacies. This table categorizes the primary financial tools used by PBMs to extract revenue from pharmacies, highlighting their retroactive nature and lack of transparency.

Of these, **Direct and Indirect Remuneration (DIR) fees** have become the most notorious and financially devastating tool. The term "DIR" originated with the Centers for Medicare & Medicaid Services (CMS) as an accounting mechanism to track all post-point-of-sale price concessions, primarily manufacturer rebates, to ensure accurate reporting of final drug costs in the Medicare Part D program.⁵⁰ However, PBMs have co-opted and expanded this concept into a mechanism for clawing back a portion of the reimbursement paid to pharmacies, often weeks or even months after a prescription has been dispensed.⁵⁴

The calculation of these DIR fees is notoriously opaque. They can be structured as a percentage of the drug's price—meaning they are larger for more expensive drugs with higher WACs—or as a flat fee per prescription.⁴⁹ PBMs often justify these fees as being tied to pharmacy "performance" on various quality metrics, but these metrics are set unilaterally by the PBM, can be irrelevant to a pharmacy's specific patient population (e.g., applying diabetes

adherence metrics to an oncology pharmacy), and are often designed to be unattainable.⁵⁰ The growth of these fees has been explosive; between 2010 and 2020, CMS reported that pharmacy DIR fees increased by an astonishing 107,400%.⁵⁴ These fees function as a direct, post-sale wealth transfer from the pharmacy to the PBM. By clawing back money retroactively, PBMs shift all financial risk to the pharmacy while guaranteeing their own profit margin after the fact, often pushing the pharmacy's net reimbursement below its actual cost to acquire the drug.⁵³

Driving Pharmacies to Extinction

The cumulative impact of below-cost reimbursements, unpredictable DIR clawbacks, and a litany of other punitive fees has created an unsustainable business environment for many retail pharmacies. The primary driver of the ongoing pharmacy closure crisis is this model of chronic under-reimbursement by PBMs.⁵⁶

The statistical evidence linking PBM practices to the decline of community pharmacy is stark and compelling:

- A study published in *Health Affairs* found that retail pharmacies excluded from Medicare Part D preferred networks—which are designed and controlled by PBMs—were as much as 4.5 times more likely to close over the past decade.⁵⁸
- Nationwide, nearly one-third of all retail pharmacies have closed since 2010. The closure risk is more than twice as high for independent pharmacies compared to chain pharmacies.⁵⁹
- The impact is not evenly distributed. Pharmacy closures disproportionately harm minority communities and low-income neighborhoods, creating "pharmacy deserts" where access to essential medications and health services is severely limited.⁵⁸
- State-level data reveals the severity of the crisis. In Minnesota, for example, an alarming 61% of all independently owned pharmacies closed their doors between 2013 and 2024.⁵⁶

The Rise of PBM-Owned "Captive" Pharmacies

The widespread closure of independent pharmacies is not merely an unfortunate side effect of market pressures; it appears to be a strategic objective of the vertically integrated PBMs. The "Big Three" PBMs are all integrated with their own massive mail-order, retail (in the case of CVS), and specialty pharmacies.⁷ These "captive" pharmacies operate under a different set of rules. They are largely insulated from the punitive fees and reimbursement pressures that are systematically applied to their independent and unaffiliated competitors. PBMs have been shown to reimburse their own pharmacies more favorably than they do non-affiliated pharmacies, creating an unlevel playing field.⁷

This creates a predatory cycle. First, PBMs impose financially unsustainable conditions on independent pharmacies, driving them out of business. Second, as these community pharmacies close, patients are left with fewer choices and are often forced to migrate to the PBM's own mail-order and specialty services or to the large chain pharmacies that have the scale to survive the reimbursement pressures and are part of the PBM's preferred network.⁹ Each independent pharmacy that closes represents a reduction in competition and a consolidation of prescription volume into channels that the PBM directly controls and from which it derives greater profit. The creation of pharmacy deserts is the direct public health consequence of a business strategy aimed at eliminating competition and maximizing captive market share.

Fortifying the Oligopoly: Suppressing Transparent Alternatives

The entrenched PBM-wholesaler oligopoly, built on a foundation of opaque pricing and misaligned incentives, actively resists and suppresses the adoption of more transparent and efficient pricing models. The current WAC-based system, with its vast "gross-to-net bubble," is deliberately maintained because it is the primary engine of intermediary profit. This final chapter will analyze how the dominant players fortify this system by leveraging its inherent complexity to block reforms. Legitimate technical concerns, such as the risk of "double rebating," are weaponized as a defense to thwart the adoption of transparent "net price" models that threaten the lucrative status quo.

The Threat of "Net Price" Models

In response to growing outrage over high drug costs and opaque business practices, a new generation of alternative pricing models has begun to emerge. These models, broadly categorized as "cost-plus" or "net pricing," are designed around the principle of transparency.⁶² Instead of basing reimbursement on an artificial and inflated benchmark like AWP, they tie payment directly to a drug's actual acquisition cost, adding a clearly defined and transparent administrative or dispensing fee.

The most well-known example is Mark Cuban's Cost Plus Drug Company, which acquires generic drugs and sells them to patients at a price calculated as its acquisition cost plus a flat 15% markup and a small pharmacy fee.⁶² This simple, transparent model has demonstrated the potential for massive savings for consumers.⁶² The pressure from these disruptors has become so significant that even the incumbent PBMs have begun to roll out their own purportedly transparent models, such as CVS Caremark's "TrueCost" and Express Scripts' "ClearCareRx".⁶³

These models represent a profound existential threat to the traditional PBM and wholesaler business models. By collapsing the gap between the list price and the net price, they eliminate the "gross-to-net bubble" from which intermediaries extract their profits. A system based on actual cost plus a flat fee offers no opportunity for profiting from retained percentage-based rebates, opaque price spreads, or fees calculated as a percentage of an inflated WAC. The widespread adoption of such a model would fundamentally disrupt the revenue streams that have made the intermediary sector so immensely profitable.

The "Double Rebating" Defense

Faced with this threat, the incumbents have marshaled various arguments to resist a systemic shift to a net-price-based inventory system. One of the most significant and technically complex defenses revolves around the manufacturer's fear of "double rebating," also known as "duplicate discounts".⁶⁵

This is a legitimate and serious concern for drug manufacturers, rooted in the fragmented nature of U.S. drug pricing. A duplicate discount occurs when a manufacturer is forced to provide two separate discounts on the same unit of a drug. The most common scenario involves government pricing programs. For example, under the 340B Drug Pricing Program, manufacturers are legally required to sell outpatient drugs to eligible safety-net

hospitals and clinics at a very steep discount. Separately, under the Medicaid Drug Rebate Program, manufacturers must pay a substantial rebate to state Medicaid agencies for drugs dispensed to Medicaid beneficiaries.⁶⁷ A duplicate discount occurs when a 340B-purchased drug is dispensed to a Medicaid patient, and the state Medicaid agency then also claims a rebate from the manufacturer for that same drug. A similar issue can arise when a drug purchased at a 340B price is dispensed to a commercially insured patient, and the PBM unknowingly submits a claim for a commercial rebate on that already-discounted unit.⁶⁵ In these situations, the combined value of the upfront discount and the back-end rebate can exceed the entire value of the drug, forcing the manufacturer to lose money on the sale.⁶⁵

Manufacturers argue that if they were to release low, net-cost inventory into the general pharmaceutical supply chain, the risk of this happening on a massive scale would be unmanageable. They fear that this low-cost inventory would inevitably get mixed with higher-cost WAC-based inventory, and without a robust system to track each package from purchase to dispense, they would be exposed to catastrophic losses from duplicate discount claims.

A System Resistant to Reform

This "double rebating" problem creates a convenient and powerful justification for maintaining the status quo. The PBMs and wholesalers who control the pharmaceutical supply chain insist on the high-WAC inventory model remaining dominant. Their refusal to develop and implement the transparent, end-to-end tracking systems necessary to segregate different types of inventory and prevent duplicate discounts is framed as a matter of logistical complexity and operational stability. However, this resistance serves a dual purpose: it protects manufacturers from a real financial risk while simultaneously protecting the intermediaries' own opaque, WAC-based revenue streams.

The result is a strategic stalemate that benefits the incumbents. Because the intermediaries who control the physical supply (wholesalers) and the claims adjudication process (PBMs) are unwilling to build the transparent infrastructure required to solve the duplicate discount problem, manufacturers remain unwilling to risk testing low, net-cost models at scale. The system's immense complexity—a complexity that the intermediaries themselves created and profit from—is thus weaponized as a shield against reform. The

double rebating issue, while a real technical challenge, is presented as an insurmountable barrier to net pricing. In reality, it is a problem that could be solved with the very data transparency and accountability that the intermediaries' business models are designed to avoid.

This dynamic grants the PBM-wholesaler oligopoly a collective veto power over any systemic change. For a new, transparent pricing model to succeed, it requires the cooperation of both the entities that control the physical distribution of drugs and the entities that control the financial payments. A manufacturer attempting to launch a drug based on a low, transparent net price would face immediate resistance. Wholesalers, who profit from high WAC, may be unwilling to handle a product that disrupts their profitable model.²⁵ PBMs, who profit from high-list-price rebates, would have no incentive to place a low-list-price, no-rebate drug favorably on their formularies.²⁷ Faced with a united front of resistance from the dominant intermediaries, any manufacturer or health plan seeking to innovate is forced to conform to the existing WAC-based system to gain market access. The parallel oligopolies thus have a collective ability to veto any disruptive innovation that threatens their shared and deeply entrenched financial interests.

Section 13. The 340B Profit Paradox: How Pharmacy Benefit Managers Reshaped a Public Health Program into a Financial Windfall

The 340B Drug Pricing Program, established by Congress in 1992, was conceived with the bipartisan and laudable goal of supporting the nation's healthcare safety net. Its mandate was to enable certain hospitals and clinics serving high volumes of low-income and uninsured patients to "stretch scarce federal resources as far as possible" by providing them with significant discounts on outpatient prescription drugs.¹ For nearly two decades, the program operated largely within this framework. However, a series of regulatory expansions, coupled with profound shifts in the structure of the U.S. pharmaceutical market, have fundamentally altered the program's character and economic impact. This report provides a comprehensive analysis of how the 340B program has been systematically transformed from a targeted support mechanism into a highly lucrative and large-scale profit center for some of the nation's largest for-profit corporations, particularly vertically integrated Pharmacy Benefit Managers (PBMs) and their affiliated pharmacy networks.

The central thesis of this analysis is that the convergence of three key developments has created this new reality. First, a 2010 regulatory guidance from the Health Resources and Services Administration (HRSA) permitted 340B-covered entities to contract with an unlimited number of outside pharmacies, opening the door for mass participation by national pharmacy chains. Second, the increasing vertical integration of the healthcare industry has allowed a few dominant PBMs to control prescription drug claims processing, specialty and mail-order pharmacy dispensing, and health insurance plan design, creating powerful conflicts of interest. Third, the widespread adoption of opaque "virtual inventory" systems, managed by third-party administrators often aligned with PBMs, has created a critical lack of traceability in 340B transactions.

This report will deconstruct the mechanisms through which these forces interact. It will demonstrate how PBM-owned contract pharmacies capture a significant portion of the financial spread between the discounted 340B acquisition cost and the much higher reimbursement rates from commercial health plans. It will analyze how the lack of transparency in virtual inventory systems facilitates the extraction of undue payments from

pharmaceutical manufacturers through unauditible rebate claims and duplicate discounts. Finally, it will explore the broader systemic consequences, presenting evidence that this new 340B ecosystem not only diverts savings away from their intended patient-centric purpose but also creates perverse incentives that may contribute to the inflation of overall U.S. drug and healthcare costs

The Original Mandate: The 340B Program's Role as a Healthcare Safety Net

To comprehend the profound transformation of the 340B Drug Pricing Program, it is essential to first establish its foundational principles and original legislative intent. Created as part of the Veterans Health Care Act of 1992, the program was a bipartisan effort designed to provide relief to a specific class of healthcare providers struggling under the weight of rising pharmaceutical costs.³ Its architecture and purpose created a baseline against which the program's modern implementation can be critically evaluated.

Legislative Origins and Bipartisan Intent

The 340B program did not emerge in a vacuum. It was modeled directly after the Medicaid Drug Rebate Program (MDRP), which was established in 1990 to protect state Medicaid programs from escalating drug prices.³ The MDRP required manufacturers to pay rebates to states as a condition of their drugs being covered by Medicaid. Lawmakers recognized that a similar protection was needed for safety-net hospitals and clinics that served a "disproportionate share" of low-income and indigent patients but were not directly covered by the MDRP's rebate structure.¹

The stated purpose of the program, articulated in congressional report language, was to enable these "covered entities" to "stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services".¹ This mandate was intentionally broad, providing flexibility for providers to use the savings generated by the program to meet the unique needs of their communities.⁶ The program operates at no direct cost to the taxpayer; the financial support is provided entirely through mandatory discounts from pharmaceutical manufacturers.⁷ Participation for manufacturers is effectively

compulsory; as a condition of having their drugs covered under the vast markets of Medicaid and Medicare Part B, they must enter into a Pharmaceutical Pricing Agreement (PPA) with the Secretary of Health and Human Services (HHS), thereby agreeing to provide 340B discounts.¹ This design, however, established a unique and inherently adversarial dynamic from the outset. Unlike government programs funded through general tax revenue, the 340B program was structured as a mandatory transfer of resources from one group of private entities (drug manufacturers) to another (healthcare providers).² This created a direct, zero-sum financial conflict between manufacturers, who have a natural incentive to limit the scope and financial impact of the discounts, and covered entities, who have an equally natural incentive to maximize the revenue generated from them. This underlying tension, combined with a lack of direct taxpayer oversight, created a fertile environment for the program's evolution to be driven by the strategic financial maneuvering of these private actors rather than exclusively by deliberate public policy.

The Core Mechanism: How Discounts Are Calculated and Delivered

The 340B program is fundamentally a program of upfront discounts, not a system of backend rebates.³ This is a critical distinction, as it means covered entities realize the savings at the time of purchase, improving their cash flow and eliminating the need to provide upfront financing for high-cost drugs. The maximum price a manufacturer can charge a covered entity is known as the "340B ceiling price".⁴

The calculation of this ceiling price is tied directly to the formulas used in the MDRP. It is determined by taking the drug's Average Manufacturer Price (AMP) and subtracting the Unit Rebate Amount (URA).⁵ The URA, for branded drugs, is the greater of 23.1% of the AMP or the difference between the AMP and the Medicaid "best price"—the lowest price offered to any wholesaler, retailer, or provider in the commercial market.⁶ This formula ensures that 340B entities receive a substantial discount, typically estimated to be between 20% and 50% of the drug's cost.⁷ The discount can be even steeper for drugs whose prices have risen faster than the rate of inflation, as an additional penalty is applied.⁸

Defining the Beneficiaries: Covered Entities and the Patient

Population

The statute explicitly defines the types of providers eligible to participate in the program as "covered entities." Initially, this included six types of hospitals—such as Disproportionate Share Hospitals (DSH), which serve a high percentage of low-income Medicare and Medicaid patients—and various federal grantees like Federally Qualified Health Centers (FQHCs) and Ryan White HIV/AIDS program grantees.¹ The list of eligible entities was later expanded under the Affordable Care Act (ACA) of 2010 to include critical access hospitals, sole community hospitals, and rural referral centers, a key factor in the program's subsequent growth.¹

A crucial and often misunderstood aspect of the program is the definition of an eligible patient. Eligibility is not determined by a patient's income level or insurance status.⁸ Rather, the Health Resources and Services Administration (HRSA), the agency tasked with overseeing the program, has defined an eligible patient as an individual who has an established relationship with the covered entity and receives healthcare services from a professional employed by or contracted with that entity.¹ This means that a covered entity can purchase and dispense 340B-discounted drugs to any of its eligible patients, including those with robust commercial insurance.

This feature is central to the program's revenue-generating mechanism. A covered entity can purchase a drug at the low 340B price, dispense it to a commercially insured patient, and receive reimbursement from the patient's insurer at a much higher, non-discounted rate. The difference, or "spread," constitutes the 340B savings. The legislative vagueness regarding the use of these savings proved to be a foundational flaw. The statute's failure to precisely define or place auditable requirements on how this revenue should be used—beyond the ambiguous mandate to "stretch scarce resources"—created what many stakeholders have described as a "black box."² This lack of specificity meant that revenue generation could become an end in itself, rather than solely a means to fund specific services for the indigent. This foundational ambiguity was the essential precondition that allowed the program's mission to drift from direct patient support toward a focus on institutional financial optimization—a drift that PBMs would later exploit and dramatically accelerate.

The Inflection Point: Contract Pharmacy Expansion and the Entry of

For-Profit Intermediaries

For nearly two decades, the 340B program's reach was largely constrained by the physical footprint of covered entities themselves. Dispensing was primarily limited to in-house pharmacies, which less than 5% of covered entities operated at the program's inception.¹ A 1996 guidance allowed for a single contract pharmacy, but it was a 2010 subregulatory guidance from HRSA that served as the catalyst for a radical transformation of the program, opening the floodgates to for-profit intermediaries and setting the stage for the dominance of PBMs.

The 2010 HRSA Guidance: Opening the Floodgates

In 2010, HRSA issued guidance that permitted covered entities to contract with an *unlimited* number of external retail, specialty, and mail-order pharmacies to dispense 340B-discounted drugs on their behalf.⁷ This decision is arguably the single most consequential development in the program's 30-year history. The stated rationale was to improve patient access to medications, particularly for patients in rural or underserved communities who might face transportation barriers to an in-house hospital pharmacy.⁶ For the many rural hospitals that lack their own pharmacies, this guidance was presented as a critical lifeline to allow their patients to conveniently access needed drugs.⁵ While the goal was laudable, the guidance unleashed a set of powerful economic forces that would reshape the 340B landscape in ways its authors likely never anticipated.

The Explosion of Contract Pharmacy Arrangements: A Quantitative Analysis

The impact of the 2010 guidance was immediate and dramatic. The number of pharmacies participating in the 340B program as contract pharmacies skyrocketed. In 2010, prior to the guidance, fewer than 1,300 unique pharmacy locations served as contract pharmacies.¹² By 2022, that number had surged to over 26,885, and by mid-2025, it stood at 32,069 unique locations—representing nearly 60% of the entire U.S. pharmacy industry.¹² This represents a

more than 4,000% increase in the use of outside contract pharmacies since the program's expansion.²

Even more telling than the number of locations is the growth in the number of unique contractual relationships, as a single pharmacy can contract with multiple covered entities. Between 2016 and 2025, the number of these relationships grew at a compound annual rate of 21%, from approximately 42,000 to nearly 230,000.¹² This explosive growth was not necessarily correlated with patient need; studies have found that the expansion of contract pharmacies was often concentrated in more affluent communities rather than in low-income areas, challenging the access-based justification for the policy change.¹⁵

Market Domination: The Rise of Vertically Integrated PBMs in the 340B Ecosystem

The contract pharmacy expansion did not create a diversified, competitive market. Instead, it was rapidly consolidated and dominated by a handful of large, publicly traded, for-profit corporations. The market power of these entities stems from their high degree of vertical integration, wherein the PBM, specialty pharmacy, mail-order pharmacy, and often a major health insurer are all owned by the same parent corporation.¹⁵ This structure grants them unparalleled control over the entire prescription drug channel, from claims adjudication to dispensing.

Analysis of the contract pharmacy market reveals the extent of this concentration. As shown in Table 1, just five companies—CVS Health, Walgreens, Cigna (via Express Scripts), UnitedHealth Group (via OptumRx), and Walmart—have dramatically increased their market share. In 2016, these five companies accounted for 55.9% of all contract pharmacy relationships. By 2025, their collective share had soared to 76.1%.¹²

Table 1: The Consolidation of the 340B Contract Pharmacy Market (2016 vs. 2025)

Company/Entity	Market Share (2016)	Market Share (2025)
CVS Health	19.3%	27.2%
Walgreens	21.0%	23.9%
Cigna (Express Scripts)	5.8%	9.0%
UnitedHealth Group (OptumRx)	2.5%	8.2%

Walmart	7.3%	7.8%
Top 5 Total	55.9%	76.1%
All Others	44.1%	23.9%
Source: Data compiled from Drug Channels Institute analysis. ¹² Market share is based on the number of unique contract pharmacy/covered entity relationships.		

The growth has been particularly pronounced in the most lucrative sectors of the pharmacy market. PBM-affiliated mail, specialty, and infusion pharmacies, while representing a small fraction of physical locations (just over 1%), now account for a staggering 25% of all 340B contract pharmacy relationships.¹² This strategic focus on high-cost specialty drugs is central to the PBM profit model within 340B.

This rapid consolidation and market entry by for-profit giants fundamentally altered the program's economic flows. The 2010 guidance inadvertently created an entirely new class of financial beneficiaries—large pharmacy chains and PBMs—that were never contemplated in the original 1992 statute.¹¹ These for-profit corporations are not passive dispensers; they actively share in the profits generated from the 340B spread, meaning a significant portion of the financial benefit intended to help non-profit safety-net providers is now being siphoned off by publicly traded companies whose primary fiduciary duty is to their shareholders, not to underserved communities.¹⁴

Furthermore, this expansion created an unmanageable compliance burden for most covered entities. The shift from managing a single in-house pharmacy to overseeing a network of potentially hundreds of external contract pharmacies created an explosion of transactional complexity. Each new pharmacy added a new stream of dispensing data that had to be meticulously reconciled against patient records to prevent diversion (dispensing to ineligible patients) and duplicate discounts.²¹ Most hospitals and clinics, whose core competency is providing healthcare, were ill-equipped to manage this operational challenge. This created a market necessity for specialized intermediaries—Third-Party Administrators (TPAs) and the sophisticated data management platforms offered by large PBMs—to administer the program. This dependency effectively ceded enormous operational control to these for-profit intermediaries, allowing them to design, implement, and manage the very

systems from which they would profit, creating a profound and systemic conflict of interest.

Deconstructing the PBM Profit Model within 340B

The entry of PBMs into the 340B ecosystem was not incidental; it was driven by a clear and powerful financial incentive. By leveraging their vertically integrated structure and their central role in the pharmaceutical supply chain, PBMs have developed a multi-layered model to extract substantial profits from the program. This model is predicated on capturing the vast financial spread created by the 340B discount, a process that is amplified by the increasing prevalence of high-cost specialty drugs.

Capturing the Spread: The Core Financial Arbitrage Opportunity

The fundamental profit mechanism in the 340B contract pharmacy arrangement is a form of financial arbitrage. The process unfolds as follows:

1. A 340B-covered entity, such as a DSH hospital, establishes a contractual relationship with a PBM-owned contract pharmacy.¹⁵
2. The covered entity purchases an outpatient drug from a manufacturer at the deeply discounted 340B price, which can be 20% to 50% or more below the average manufacturer price.¹
3. The PBM's contract pharmacy dispenses this drug (or an identical one from its general stock, to be replaced later) to an eligible patient who is covered by a commercial health plan—a plan often managed by the very same PBM.¹⁴
4. The PBM, acting as the plan administrator, reimburses its own pharmacy at a much higher, commercially negotiated rate and bills the health plan (the employer or insurer) that higher rate.²⁴

The enormous difference between the 340B acquisition cost and the final commercial reimbursement is the gross profit, or "spread." This spread, which can be substantial, is then shared between the covered entity and the PBM's contract pharmacy according to the terms of their agreement.²³

A Multi-Layered Revenue Strategy: Dispensing Fees, Shared Savings,

and Administrative Charges

The compensation for contract pharmacies is not uniform and reveals a sophisticated revenue strategy. While some arrangements involve a simple flat dispensing fee paid by the covered entity to the pharmacy for each prescription, many of the more lucrative agreements, particularly those involving PBM-owned pharmacies, are structured differently. These often involve the pharmacy retaining a percentage of the total reimbursement or a share of the generated profit.²⁰

This percentage-based model creates a clear and perverse financial incentive: the higher the price of the drug dispensed, the greater the revenue for the contract pharmacy and, by extension, its PBM owner. This can create an economic pressure to favor higher-cost brand-name drugs over less expensive generics, as this maximizes the shared revenue from the 340B transaction.²⁷

Beyond direct profit sharing, PBMs employ other tactics to maximize revenue. One is "spread pricing," where the PBM charges the health plan a higher price for a drug than it reimburses the pharmacy, pocketing the difference. While this is a common practice in the broader PBM market, it takes on a new dimension in the 340B context, where the initial acquisition cost is already artificially low.¹⁶ Another key strategy is patient steering. PBMs, as administrators of health plans, have the power to designate their own mail-order and specialty pharmacies as preferred or exclusive providers, thereby directing a high volume of prescriptions—including many that are 340B-eligible—to their own businesses.³⁰

The Specialty Pharmacy Multiplier: How High-Cost Drugs Amplify PBM Profits

The profitability of the 340B program for PBMs has been supercharged by the rise of high-cost specialty drugs. Because the 340B discount is calculated as a percentage of the drug's price, the absolute dollar value of the discount—and therefore the potential profit spread—is vastly larger for an expensive biologic or oncology drug than for a common medication for a chronic condition.

Recognizing this, PBMs have aggressively expanded their specialty pharmacies' participation in the 340B program.¹² These PBM-owned specialty pharmacies have become a

focal point of 340B profitability. Analyses have shown that a specialty pharmacy can earn profits from a 340B-adjudicated prescription that are three to four times larger than the profit from a typical commercial or Medicare Part D prescription for the same drug.¹⁹ This enormous profit differential, illustrated in Table 2, explains why PBMs have invested so heavily in growing their 340B specialty pharmacy business.

Table 2: Illustrative Profit Comparison for a Specialty Drug: 340B vs. Non-340B Dispense

Financial Metric	Scenario 1: Non-340B Dispense	Scenario 2: 340B Dispense
Drug List Price (WAC)	\$5,000	\$5,000
340B Acquisition Cost	N/A	\$1,250
PBM Reimbursement to Pharmacy	\$4,500	\$4,500
Patient Coinsurance (20% of List Price)	\$1,000	\$1,000
Net Payer Cost	\$3,500	\$3,500
Gross Profit to Pharmacy	\$500	\$1,610
Gross Profit to Covered Entity	\$0	\$1,640
Total System Profit (Spread)	\$500	\$3,250
Note: This is a simplified, illustrative example based on principles and figures from sources. ¹⁹ Pharmacy profit in Scenario 2 assumes a 50/50 profit share with the covered entity after accounting for a dispensing fee. Actual figures vary by drug, contract, and payer.		

This example demonstrates how the introduction of the 340B discount transforms the transaction. While the cost to the payer and patient remains identical, the total profit generated by the system increases from \$500 to \$3,250. This additional \$2,750 is captured

entirely by the covered entity and the PBM-owned contract pharmacy, funded by the mandatory discount provided by the manufacturer.

Financial Disclosures as Evidence: Quantifying the 340B Impact on PBM Bottom Lines

The financial materiality of the 340B program to PBMs is no longer a matter of speculation; it has been confirmed through their own public financial disclosures. In one notable instance, CVS Health reported that changes to 340B contract pharmacy arrangements contributed to a \$1.2 billion reduction in its operating income over a single three-month period.³² Such a disclosure would not be made unless the revenue stream was of core importance to the corporation's overall financial health. Similarly, Walgreens disclosed that manufacturer restrictions on 340B would reduce its profits by approximately \$250 million over two fiscal years.³³

Industry-wide estimates further quantify the scale of this profit center. In 2023, the total estimated gross profits from the 340B program for the five largest contract pharmacy operators were nearly \$3 billion.³³ Other analyses have found that more than 50 cents of every dollar in profit generated by contract pharmacies in the 340B program go to just four large companies: Walgreens, Walmart, CVS Health, and Express Scripts.¹⁵

This evidence reveals that 340B is not a marginal revenue stream but has become a key subsidizer of PBMs' core business operations. The super-profits generated through these arrangements may allow PBMs to offer more aggressive pricing and competitive bids to health plans for their non-340B business, knowing they can compensate for lower margins in one area with the exceptionally high margins from 340B. In this way, a program designed to provide a financial lifeline to safety-net hospitals now functions as an indirect subsidy for the market-share-driven business strategies of the nation's largest and most profitable healthcare corporations.

The "Virtual Inventory" Black Box: How Operational Opacity Enables Financial Extraction

The vast financial opportunities within the 340B contract pharmacy system are made

possible by a critical operational vulnerability: the near-total lack of transparency and traceability inherent in the dominant "virtual inventory" model. This model, managed by Third-Party Administrators (TPAs) that are often aligned with or owned by PBMs, creates an informational black box. This opacity severs the link between a physical drug dispensed to a patient and the 340B-discounted replenishment order, making it nearly impossible for manufacturers to verify the legitimacy of claims and creating a fertile ground for financial extraction and abuse.

The Mechanics of Virtual Inventory and Third-Party Administrators (TPAs)

When a covered entity partners with a contract pharmacy, it has two primary options for managing its 340B drug stock. The first is to maintain two physically separate inventories at the pharmacy: one for 340B-purchased drugs and one for non-340B drugs.³⁴ This model is operationally cumbersome, requires significant physical space, and is rarely used.

The second, and overwhelmingly dominant, model is the "virtual inventory".³⁴ Under this system, the contract pharmacy dispenses all drugs from a single, commingled stock. The determination of whether a dispense qualifies for a 340B discount is made retrospectively by a TPA using specialized software.³⁵ The workflow is a complex interplay of data from disconnected sources:

1. **Dispense:** A patient, who may be 340B-eligible, fills a prescription at a contract pharmacy. The pharmacy dispenses the drug from its general inventory and adjudicates the claim through the patient's PBM in the normal course of business.³⁵ At this point, the transaction is indistinguishable from any other prescription.
2. **Data Ingestion:** After the fact, the TPA's software system pulls in two separate data feeds: a record of all prescriptions dispensed from the contract pharmacy (often from the pharmacy's "switch" vendor) and patient encounter data from the covered entity's Electronic Medical Record (EMR) system.³⁵
3. **Retrospective Matching:** The TPA's proprietary algorithm attempts to match the pharmacy dispensing data with the EMR data to identify prescriptions that were filled for patients who had a qualifying healthcare encounter with the covered entity.³⁵ This matching process is the "black box" of the system, governed by business rules and logic

that are not transparent to outside parties.³⁶

4. **Virtual Accumulation:** When the TPA's software identifies a "match," it flags the dispense as 340B-eligible and adds it to a virtual accumulator for that specific drug (identified by its National Drug Code, or NDC).³⁵
5. **Replenishment Trigger:** The TPA continues to accumulate these virtual dispenses. Once the total quantity dispensed equals a full, standard package size of the drug (e.g., a bottle of 30 pills, one inhaler), the system automatically triggers a replenishment order.³⁵
6. **Discounted Purchase:** The replenishment order is sent to a wholesaler. The covered entity pays the manufacturer the deeply discounted 340B ceiling price for the drug. The wholesaler then ships a new package of the drug to the contract pharmacy to replace the unit that was previously dispensed from its general stock.³⁵

The Traceability Gap: Why Manufacturers Cannot Verify Claims

This retrospective, data-driven process creates a critical information asymmetry and a "traceability gap." The pharmaceutical manufacturer receives a replenishment order for a drug at the 340B price, but it has absolutely no access to the underlying patient data, prescription claim, or EMR encounter record that the TPA used to justify that order.³⁷ The data is fragmented and siloed across multiple, independent parties—the pharmacy, the TPA, the PBM, and the covered entity—none of whom are obligated to provide auditable proof to the manufacturer that the replenishment is legitimate.³⁷ The complexity is further magnified by the constant flux of NDCs for the same drug due to shortages and supplier changes, making a true one-to-one tracking nearly impossible without a unified system.³⁸ From the manufacturer's perspective, the system is fundamentally unauditible.

This operational structure effectively creates a "reverse burden of proof." In a normal commercial transaction, the party seeking a discount is responsible for demonstrating its eligibility. In the 340B virtual inventory system, the opacity of the TPA's process shifts the burden to the manufacturer to *disprove* the validity of a replenishment order for which it has been given no data. The TPA, which has a direct financial incentive to maximize the number of "qualified" claims, acts as both player and referee, controlling the proprietary software and rules that determine eligibility without external validation.³⁵

Exploiting the Gap: Duplicate Discounts and Undocumented Rebate Demands

This traceability gap is the direct enabler of "duplicate discounts," one of the most significant and costly forms of 340B abuse. A duplicate discount occurs when a manufacturer is forced to provide two discounts on the same unit of a drug: first, the upfront 340B price to the covered entity for the replenishment order, and second, a backend rebate to a state Medicaid agency or a PBM for the original dispense.²

The problem stems from the fact that at the point of sale, the 340B-eligible claim is not flagged or identified in any way that is visible to the PBM or the manufacturer.³⁶ The PBM processes the claim like any other and includes it in the large data files it sends to manufacturers to claim quarterly rebates. Because the manufacturer has no way of knowing which of the millions of claims in that file were already subject to a 340B discount via the TPA's retrospective process, it is at risk of paying twice. An estimated \$933 million to \$1.6 billion in duplicate discounts occurred as of 2019 alone.² This lack of traceability is precisely what allows a PBM to, as the user query suggests, demand rebate payments from manufacturers with little to no auditable documentation. The manufacturer is forced to either pay the rebates on faith or engage in a costly and data-blind dispute.

The Quarterly Reckoning: How Opaque Settlements Obscure True Costs

Given the impossibility of verifying individual claims, disputes between manufacturers and PBMs or covered entities over duplicate discounts are not resolved on a claim-by-claim basis. Instead, they are typically handled through opaque, high-level negotiations that result in lump-sum settlements at the end of each quarter. This "quarterly reckoning" allows all parties to resolve financial discrepancies without ever fixing the underlying systemic flaws. It obscures the true volume of improper claims, allows the financial leakage to persist, and perpetuates the cycle of unauditible transactions. The federal government's creation of a formal Administrative Dispute Resolution (ADR) process is a tacit acknowledgment that these conflicts are systemic and deeply embedded in the program's flawed operational structure.⁵

Systemic Consequences: The Ripple Effects on U.S. Healthcare Costs

The transformation of the 340B program into a profit center for PBMs and large hospital systems has consequences that extend far beyond the program's internal mechanics. The powerful financial incentives embedded in the modern 340B ecosystem create a series of perverse ripple effects that distort market behavior, fuel healthcare consolidation, and, paradoxically, contribute to the very problem of high healthcare costs that the program was originally intended to mitigate.

The Hidden Cost Shift: How Commercial Payers and Employers Subsidize 340B Profits

A growing body of evidence indicates that the 340B program creates a significant, hidden cost shift onto the commercial insurance market. Independent analysis has found that commercial prices for both outpatient procedures and physician-administered drugs are substantially higher at 340B-participating hospitals compared to their non-340B counterparts. One study found that commercial prices were roughly 7% higher at large 340B hospitals, and prices for outpatient procedures were nearly 20% higher.³⁹

This "340B price premium" translates into an estimated \$36 billion a year in additional hospital spending by employers and the working families they cover.³⁹ This dynamic represents a direct cost shift. The profits generated by hospitals and their contract pharmacy partners from the 340B spread are not created in a vacuum; they are effectively funded by higher charges to commercial health plans, which in turn leads to higher premiums and out-of-pocket costs for American workers and their families. The program's financial arbitrage mutes the normal market pressures that would typically drive down commercial prices, as a hospital's profit is maximized when the spread between its low acquisition cost and the high commercial reimbursement rate is largest. This weakens the incentive for some of the market's largest buyers—hospital systems—to aggressively negotiate lower commercial prices.

Perverse Incentives: The Link Between 340B and Higher-Priced Drug

Utilization

The structure of 340B profit—the spread between the acquisition cost and the reimbursement—creates a powerful incentive for covered entities and their partners to favor the use of higher-priced drugs. Because the 340B discount is percentage-based, the absolute dollar profit on an expensive specialty drug is exponentially greater than on a lower-cost generic or biosimilar alternative.²³

This incentive appears to influence clinical and prescribing patterns. Research from the Government Accountability Office (GAO) and other academic studies has shown that 340B hospitals tend to have significantly higher Medicare Part B drug spending per beneficiary than non-340B hospitals.⁴⁰ This discrepancy suggests that 340B eligibility is associated with either a higher quantity of drugs being prescribed or a shift toward more expensive drug therapies.⁴⁰ This dynamic runs counter to broader healthcare goals of promoting the use of the most cost-effective treatments and can drive up overall spending for payers like Medicare.

Fueling Consolidation: 340B's Role in Hospital Acquisition of Physician Practices

The immense revenue potential of the 340B program has become a significant driver of healthcare market consolidation. There is a strong financial incentive for 340B-eligible hospitals to acquire independent physician practices, particularly in drug-intensive specialties such as oncology, rheumatology, and ophthalmology.⁴⁰

Before acquisition, an independent oncology practice purchases chemotherapy drugs at or near wholesale prices. After being acquired by a 340B hospital and designated as a hospital outpatient department, that same clinic can now purchase those same drugs at the deep 340B discount. Because reimbursement rates from Medicare and commercial payers are often higher for services delivered in a hospital outpatient setting, the acquisition instantly transforms the practice's drug-related activities from a cost center into a massive revenue generator for the hospital system. This "buy low, bill high" opportunity has fueled a wave of vertical integration, contributing to the decline of independent physician practices and leading to less competition and higher overall prices for care.⁴⁰

The Patient Paradox: How a Program for the Indigent Can Increase Out-of-Pocket Costs

Perhaps the most troubling consequence of the program's evolution is the disconnect between its intended beneficiaries and its actual financial impact on patients. Despite the program's safety-net mission, there is no federal requirement for hospitals to pass on 340B savings to patients. Numerous studies and GAO reports have found that a majority of hospitals do not provide discounted 340B drug prices to low-income, uninsured patients who fill their prescriptions at a contract pharmacy.² These vulnerable patients may be charged the full retail price for a drug that the hospital acquired at a massive discount.

For patients with commercial insurance, the paradox is even more acute. A patient's deductible and coinsurance obligations are typically calculated based on the drug's high list price, not the secret, discounted 340B price paid by the covered entity.¹⁹ This can lead to situations where a patient with cancer, for example, pays thousands of dollars in out-of-pocket costs for a specialty drug, unknowingly funding a significant portion of the multi-thousand-dollar profit that the hospital and its PBM partner are generating from that very same prescription.¹⁹ In this way, a program designed to alleviate financial burdens on the healthcare system can directly increase the financial toxicity of care for individual patients.

Section 14. Price Distortions in the Medical Benefit: An Analysis of Perverse Incentives and Vertical Integration in the U.S. Pharmaceutical Supply Chain

The reimbursement of pharmaceuticals in the United States is bifurcated into two distinct channels: the pharmacy benefit and the medical benefit. While the pharmacy benefit is characterized by the aggressive management of Pharmacy Benefit Managers (PBMs), the medical benefit—which covers drugs administered in a clinical setting—operates under a different set of rules and incentives. This report provides an exhaustive analysis of the price distortions that arise within the medical benefit channel, driven by a complex interplay of misaligned financial incentives, increasing vertical integration, and significant gaps in regulatory oversight.

This analysis details four interconnected phenomena that systematically inflate costs for payers, employers, and patients. First, it examines how commercial insurers and their PBMs profit from the less-transparent medical benefit through inflated markups on provider-administered drugs and the application of opaque practices like spread pricing. Second, the report deconstructs the strategic "shell game" wherein vertically integrated healthcare conglomerates shift high-cost specialty drugs between the medical and pharmacy benefits to maximize control and reallocate profits from independent providers to their own captive specialty pharmacies. Third, it dissects the "ASP feedback loop," a perverse incentive structure created by the Average Sales Price (ASP) plus percentage reimbursement model, which financially rewards physicians for prescribing more expensive medications and encourages manufacturers to maintain high list prices. Finally, the report investigates the emerging and concerning trend of major pharmaceutical wholesalers acquiring physician practices, representing a new frontier of vertical integration that aims to control the final and most critical step in the supply chain: the physician's prescribing decision.

Collectively, these dynamics create a vicious cycle of rising expenditures. Each stakeholder—from manufacturer to insurer to wholesaler—acts rationally within the confines of a dysfunctional system, but the cumulative effect is a market that rewards high prices over value, discourages price competition, and ultimately compromises patient care. This report concludes by outlining a series of policy recommendations aimed at enhancing transparency,

realigning financial incentives with clinical value, and strengthening the regulatory and antitrust oversight necessary to correct these systemic distortions.

The Dual-Benefit Labyrinth: Medical vs. Pharmacy Reimbursement Models

To comprehend the price distortions endemic to the U.S. pharmaceutical market, one must first understand the foundational split between the medical benefit and the pharmacy benefit. These two channels operate as parallel but fundamentally different ecosystems for drug reimbursement, and their structural disparities create the conditions for the strategic arbitrage and misaligned incentives detailed throughout this report.¹

The "Buy-and-Bill" Ecosystem of the Medical Benefit

The medical benefit covers services rendered in a clinical setting, such as a physician's office, infusion center, or hospital outpatient department (HOPD).² For pharmaceuticals, this channel is defined by the "buy-and-bill" model.¹

Process Flow: The process is provider-centric and retrospective. The healthcare provider purchases specialty drugs—often expensive biologics for conditions like cancer or rheumatoid arthritis—directly from a manufacturer or a specialty distributor.⁴ The provider then stores this inventory, administers the drug to the patient, and subsequently submits a claim to the patient's insurer for reimbursement of both the drug's cost and the administration service.² Because treatment precedes payment, this model places significant upfront financial risk on the provider, who may wait weeks or longer for reimbursement.⁴

Billing and Coding: Claims are submitted using medical billing forms, such as the CMS-1500, and rely on the Healthcare Common Procedure Coding System (HCPCS).⁶ Drugs are identified by specific HCPCS codes, often referred to as "J-codes," while the act of administration is billed using separate Current Procedural Terminology (CPT) codes.² This coding system is notably less granular than the one used for the pharmacy benefit, a critical distinction that impacts cost management capabilities.⁹

Reimbursement Basis: For Medicare Part B, reimbursement for most physician-administered

drugs is statutorily set at the drug's Average Sales Price (ASP) plus a 6% add-on payment to cover handling and overhead costs.¹² Commercial health plans, however, are not bound by this rate. Their reimbursement is dictated by negotiated contracts with providers and can vary dramatically. Commercial reimbursement may be based on a multiple of ASP (e.g., ASP times three), a percentage of the drug's acquisition cost, or, particularly in the HOPD setting, a percentage of the provider's billed charges.² Because hospitals determine their own charges, this last method can lead to exceptionally high reimbursement rates.¹⁵

The PBM-Managed Ecosystem of the Pharmacy Benefit

The pharmacy benefit covers outpatient prescription drugs that are typically self-administered by the patient, such as oral medications or self-injectables.¹⁶ This channel is dominated by a powerful intermediary: the Pharmacy Benefit Manager (PBM).

Process Flow: In this model, a physician writes a prescription, which the patient takes to a retail or specialty pharmacy. The pharmacy dispenses the drug and, at the point of sale, submits a claim electronically to the PBM. The PBM adjudicates the claim in real-time on behalf of the insurer, determining the patient's copayment or coinsurance and the amount the PBM will reimburse the pharmacy.² The pharmacy collects the patient's cost-share and is later paid the remainder by the PBM.⁵

Role of the PBM: As previously discussed, the PBM is the central architect of the pharmacy benefit. PBMs perform several core functions, including creating and managing drug formularies (lists of covered drugs), negotiating rebates with manufacturers in exchange for preferred formulary placement, establishing networks of contracted pharmacies, and implementing utilization management tools like prior authorization (PA), step therapy, and quantity limits.²² This active management role is largely absent from the traditional "buy-and-bill" medical benefit model.⁶

Billing and Coding: Pharmacy benefit claims are processed using the unique 11-digit National Drug Code (NDC) assigned to every drug product.² This highly specific code allows for precise tracking, pricing, and management of pharmaceuticals, a stark contrast to the broader J-codes used on the medical side.⁹

The profound operational differences between these two benefits create a

"management gap." The medical benefit is a fragmented, provider-driven system with retrospective payment and less precise oversight. The pharmacy benefit is a centralized, PBM-driven system with real-time controls and granular data. This structural dichotomy is not merely an administrative detail; it is a fundamental vulnerability in the U.S. healthcare system that allows sophisticated, vertically integrated entities to strategically select the reimbursement channel that offers the path of least resistance and greatest profit.

Feature	Medical Benefit	Pharmacy Benefit
Drug Acquisition Model	"Buy-and-Bill": Provider purchases, stores, and administers drug ²	Pharmacy dispenses drug from its inventory to patient ²
Primary Biller	Healthcare Provider (Physician Office, HOPD) ²	Pharmacy (Retail, Specialty, Mail-Order) ²
Billing Codes	HCPCS ("J-codes") for drug; CPT for administration ²	National Drug Code (NDC) for drug product ²
Claim Adjudication	Retrospective (weeks to months after administration) ⁴	Real-time at the point of sale ¹
Primary Management Entity	Health Insurer (Payer) ²	Pharmacy Benefit Manager (PBM) ⁴
Key Reimbursement Benchmarks	Average Sales Price (ASP), Wholesale Acquisition Cost (WAC), Percentage of Billed Charges ¹²	Average Wholesale Price (AWP), Maximum Allowable Cost (MAC) ²⁸
Common Utilization Management	Less structured; primarily PA based on medical necessity ⁴	Highly structured; Formulary Tiers, PA, Step Therapy, Quantity Limits ⁴

Profiteering in Plain Sight: Insurer and PBM Revenue Models in the Medical Benefit

While the medical benefit channel is often perceived as a straightforward fee-for-service arrangement between providers and payers, it contains opaque and lucrative revenue streams for insurers and their PBMs. The relative lack of transparency and management compared to the pharmacy benefit allows for significant markups and profit-generating practices that contribute to rising healthcare costs.

The Markup Mechanism: Commercial Payer Reimbursement vs. Medicare Rates

A primary source of price distortion stems from the vast difference between Medicare's regulated payment rates and the negotiated rates paid by commercial insurers. While Medicare Part B reimbursement is tethered to a transparent formula of ASP+6%¹³, commercial plans operate with far fewer constraints, leading to dramatically inflated payments for the same drugs.¹²

Recent analyses leveraging new hospital price transparency data reveal the scale of these markups. Top-performing U.S. hospitals routinely charge commercial insurers prices that are multiples of the Medicare payment limit. One study found median negotiated prices for clinician-administered drugs ranged from 169% to 344% of the Medicare rate.¹⁵ Another analysis found that hospitals eligible for federal discounts charge insurers 300% more than their acquisition cost for infused drugs, while other hospitals impose an average markup of 240%.³³

This phenomenon is exacerbated in the hospital outpatient department (HOPD) setting, where reimbursement is frequently based on a percentage of the hospital's billed charges.² Because hospitals have wide latitude in setting these charges, they can be inflated to levels that bear little resemblance to the drug's actual acquisition cost. This creates a powerful incentive for hospitals to favor and administer high-cost drugs, as a percentage of a larger number yields greater revenue.³⁴

The case of Jeffrey Kivi, a patient receiving infusions of the drug Remicade, provides a stark real-world example. When his physician moved to a new hospital, the billed charge for his monthly infusion skyrocketed from \$19,000 to over \$132,000. His commercial insurer paid approximately \$100,000 of this inflated charge without apparent resistance, illustrating a system where both the provider and the insurer can benefit from a higher price point.³⁵ This dynamic suggests a counterintuitive alignment of interests: insurers, who derive revenue from administrative fees calculated as a percentage of total medical spending, have a diminished incentive to aggressively negotiate down costs. Higher baseline spending can translate into higher administrative fees from self-funded employer clients and provide justification for future premium increases in fully insured plans. The opacity of medical benefit billing makes it easier to embed these markups, shielding the true cost from the ultimate payer.

PBM Tactics on the Medical Benefit: Spread Pricing and Rebate Retention

PBMs, though primarily associated with the pharmacy benefit, also apply their profit-generating tactics to drugs covered under the medical benefit, particularly within managed Medicaid programs.

- **Spread Pricing:** This practice involves the PBM charging the health plan a higher price for a drug than it reimburses the pharmacy or provider, retaining the difference—the “spread”—as profit.²⁰ While less visible than on the pharmacy side, investigations in states like Ohio, Michigan, and Maryland have revealed that PBMs have pocketed hundreds of millions in taxpayer dollars through spread pricing on Medicaid medical claims.³⁸ An audit in Ohio found PBMs collected \$224.8 million in spread in a single year.³⁸
- **Rebate Retention:** Payers and PBMs are increasingly negotiating manufacturer rebates for provider-administered drugs, mirroring the system on the pharmacy benefit.⁶ This creates an incentive for health plans to favor high-list-price, high-rebate drugs. Because plans often pass through little to none of the medical benefit rebates they receive to their employer group clients, the full value of the rebate can be retained as profit.⁷ This dynamic further entrenches high list prices and obscures the true net cost of medications.

The Shell Game: Strategic Benefit Shifting by Vertically Integrated Entities

One of the most significant trends distorting pharmaceutical costs is the strategic shifting of specialty drugs between the medical and pharmacy benefits. This “shell game” is orchestrated by vertically integrated entities—corporations that own the health insurer, the PBM, and the specialty pharmacy—to gain control over drug distribution and reallocate profits from independent providers to their own captive business units.

The Financial Logic of Shifting Drugs to the Pharmacy Benefit

Health plans are increasingly mandating that high-cost specialty drugs, traditionally administered in a physician's office under the "buy-and-bill" model, be covered through the pharmacy benefit instead.³⁹ The publicly stated rationale is cost control. By moving a drug to the pharmacy benefit, the PBM can deploy its full arsenal of management tools, including strict formularies, prior authorization, step therapy, and quantity limits.⁹ This channel also allows the PBM to leverage its immense purchasing volume to negotiate larger manufacturer rebates, which are typically less prevalent or smaller on the medical benefit.¹

However, this narrative of simple cost control is incomplete. The shift is more accurately a strategy of profit reallocation. Under the "buy-and-bill" model, the provider earns a margin between their acquisition cost for a drug and the insurer's reimbursement.⁵ By shifting the drug to the pharmacy benefit, the vertically integrated insurer-PBM strips the provider of this revenue stream and redirects it to its own in-house specialty pharmacy, which now dispenses and bills for the drug.⁴³ The total cost to the system may not decrease, but the distribution of profit is fundamentally altered in favor of the integrated corporation.

Mechanisms of the Shift: "White Bagging" and "Brown Bagging"

The primary mechanisms for executing this shift are known as "white bagging" and "brown bagging." Both practices circumvent the provider's role in procuring medication.⁸

- **White Bagging:** The insurer or PBM mandates that a patient's drug be dispensed by a specific (often PBM-owned) specialty pharmacy. That pharmacy then ships the patient-specific medication directly to the physician's office or hospital for administration. The provider is only able to bill for the administration service, not the drug itself.⁸
- **Brown Bagging:** In this scenario, the specialty pharmacy dispenses the drug directly to the patient, who is then responsible for storing it and bringing it to their appointment for administration.⁸

The Role of Vertical Integration

This strategic benefit shifting is enabled by the massive consolidation and vertical integration within the U.S. healthcare industry. Three dominant entities—UnitedHealth Group (owning OptumRx PBM and OptumCare providers), CVS Health (owning Aetna insurer, Caremark PBM, and CVS Specialty pharmacy), and Cigna (owning Express Scripts PBM and Accredo specialty pharmacy)—now control nearly 80% of the PBM market and have extensive ownership across the supply chain.²³

This integration creates powerful incentives for self-dealing. These firms can design benefit plans that mandate the use of their own specialty pharmacies, effectively locking in a captive customer base and steering revenue internally. A 2021 study of Medicare Part D data found clear evidence of this behavior, showing that insurer-PBM-owned pharmacies fill a significantly higher share of prescriptions for their own plan members compared to members of other plans, a strong indicator of patient steering.⁴⁹ While vertical integration can theoretically create efficiencies by eliminating "double marginalization," it also creates anticompetitive risks, as the integrated PBM has an incentive to harm rival insurers by offering them less favorable terms and passing through a smaller share of rebates.⁴⁸

The ASP Feedback Loop: Perverse Incentives in Physician-Administered Drug Reimbursement

The reimbursement methodology for physician-administered drugs under the medical benefit, particularly the Average Sales Price (ASP) model used by Medicare, creates a system of perverse financial incentives that encourages the use of higher-cost medications and discourages price competition among manufacturers. This "ASP feedback loop" is a core driver of price distortion in the "buy-and-bill" ecosystem.

Deconstructing the ASP+X% Formula

Established by the Medicare Modernization Act of 2003, the ASP-based system was intended to replace the easily manipulated Average Wholesale Price (AWP) benchmark with a more transparent, market-based price.¹⁴ The ASP for a given drug is calculated quarterly by the Centers for Medicare & Medicaid Services (CMS). Manufacturers are required to submit data

on their total sales revenue and volume to all U.S. purchasers. CMS then calculates a volume-weighted average price that is net of most discounts and rebates.¹³ The Medicare reimbursement rate is then set at 106% of this ASP (or ASP+6%).³² The 6% add-on is intended to cover providers' costs for drug acquisition, storage, handling, and other overhead.⁵²

The Physician's Incentive: Maximizing the Margin

The fundamental flaw in the ASP+X% model is that the provider's add-on payment is a percentage of the drug's cost. This structure creates a direct financial incentive to prescribe more expensive drugs, as a fixed percentage of a higher-priced drug results in a larger absolute dollar margin for the practice.⁷ As the table below illustrates, when faced with two clinically similar drugs, a physician has a financial incentive to choose the more expensive option. This dynamic can lead to higher overall spending and may not align with the patient's best interest or the most cost-effective treatment pathway.⁷

Drug Scenario	Average Sales Price (ASP)	Reimbursement Rate (ASP + 6%)	Physician Margin (6% of ASP)
Drug A (Competitor)	\$1,000	\$1,060	\$60
Drug B (Higher-Priced)	\$2,000	\$2,120	\$120
Drug C (Biosimilar)	\$700	\$742 (ASP + 6% of its own ASP)	\$42

The Manufacturer's Playbook: The Strategy of High List Prices

Manufacturers operate within this system and respond to its incentives. They have a clear motivation to maintain high list prices, which translate to a high ASP, for several reasons. First, a higher ASP makes their product more financially attractive to physicians, helping to maintain or grow market share against lower-priced competitors.⁷

Second, high list prices are crucial for negotiations with PBMs on the pharmacy benefit side. PBMs favor drugs with high list prices because it allows them to negotiate larger rebates, which are typically calculated as a percentage of the list price. A larger rebate allows the PBM to demonstrate greater "savings" to its clients while potentially retaining a larger portion for

itself.⁵⁸ Research has shown a direct correlation, with a \$1 increase in rebates being associated with a \$1.17 increase in list prices.⁶¹ This cross-benefit dynamic means manufacturers are reluctant to lower list prices, as doing so would weaken their negotiating position with PBMs and reduce the financial incentive for physicians to prescribe their drug under the medical benefit.

This system effectively creates a "price floor" and actively impedes the adoption of lower-cost alternatives like biosimilars. When a cheaper biosimilar enters the market, its lower ASP results in a smaller dollar margin for the physician, creating a disincentive for its use.⁵⁴ Furthermore, if a manufacturer offers aggressive discounts to gain market share, it drives down the ASP for the entire drug code in the following quarter. This can leave providers who purchased the drug at a higher price "upside down," where their reimbursement is less than their acquisition cost, making them financially vulnerable.⁷ This risk discourages manufacturers from engaging in robust price competition and encourages providers to stick with higher-priced originator products.

Regulatory Blind Spots and CMS Oversight

The integrity of the ASP system depends on the accuracy of manufacturer-submitted data. While CMS has oversight procedures, the Office of Inspector General (OIG) has identified gaps and noted that manufacturers often rely on "reasonable assumptions" in their calculations due to a lack of specific guidance, particularly around complex issues like bona fide service fees (BFSFs) versus price concessions.⁶³ While manufacturers are legally required to report sales to all purchasers, preventing the most blatant forms of data manipulation, the complexity of the system allows for interpretations that can influence the final ASP calculation.⁶⁶

The New Gatekeepers: Wholesaler Acquisition of Physician Practices

A new and disruptive trend is reshaping the landscape of provider-administered drugs: the vertical integration of pharmaceutical wholesalers with physician practices. This movement represents a strategic effort by the supply chain's largest middlemen to extend

their influence from drug distribution directly to the point of clinical decision-making, raising significant competitive and ethical concerns.

The Rise of Vertical Integration in the Provider Space

The three dominant U.S. pharmaceutical wholesalers—McKesson, Cardinal Health, and Cencora—which collectively control over 90% of the wholesale market, are actively acquiring physician practices and management services organizations (MSOs).⁶⁷ These acquisitions are concentrated in specialties that rely heavily on expensive, physician-administered drugs, such as oncology, gastroenterology, and rheumatology.⁶⁹ This strategy is part of a broader "arms race" in healthcare, where non-traditional players, including health insurers and private equity firms, are buying up physician practices to control the flow of healthcare dollars.⁷²

Acquiring Wholesaler	Acquired Entity / Partner	Specialty	Reported Deal Value / Date
McKesson	US Oncology	Oncology	\$2.2 billion (2010) ⁷¹
McKesson	Florida Cancer Specialists (Core Ventures)	Oncology	\$2.49 billion (Agreement, Aug 2024) ⁶⁹
Cardinal Health	GI Alliance	Gastroenterology	\$3.9 billion (Proposed) ⁷⁴
Cardinal Health	Integrated Oncology Network (ION)	Oncology	Acquisition Completed (2024) ⁷⁴
Cardinal Health	Specialty Networks (UroGPO, Gastrologix, United Rheumatology)	Urology, Gastroenterology, Rheumatology	\$1.2 billion (Jan 2024) ⁷⁰

Wholesaler Motivations and Strategic Goals

The financial incentives driving these acquisitions are multifaceted and aimed at consolidating market power.

- **Securing Distribution Channels:** By owning or managing physician practices, wholesalers can lock them into exclusive or "prime vendor" agreements, guaranteeing a captive market for their distribution services and effectively foreclosing competition

from rival wholesalers.⁷⁴

- **Influencing Prescribing and Maximizing Profit:** Ownership creates a profound conflict of interest. The wholesaler is positioned to influence or pressure employed physicians to prescribe drugs that are most profitable for its other business units, such as its Group Purchasing Organizations (GPOs) or affiliated specialty pharmacies.⁷¹ This could involve steering physicians toward higher-cost drugs that generate larger margins or rebates for the parent company, regardless of whether they are the optimal clinical choice for the patient.⁷¹
- **Controlling the "Final Mile" of the Supply Chain:** This strategy represents a move beyond logistics to control the very act of prescription. While PBMs exert demand-side control through formularies and benefit design, wholesaler-provider integration is a supply-side strategy to directly influence the prescriber's decision at the point of care. This creates a closed-loop system where a single corporation can profit from distribution, GPO fees, practice management, and the margin on the drug itself.

Antitrust and Anti-Kickback Implications

This wave of consolidation is attracting intense regulatory scrutiny. Lawmakers have urged the Federal Trade Commission (FTC) to block these mergers, arguing they substantially lessen competition and create monopolies in violation of the Clayton Act.⁷⁴

Furthermore, these arrangements raise serious questions under federal fraud and abuse laws. The Anti-Kickback Statute (AKS) makes it a felony to offer or receive remuneration to induce referrals for services paid for by federal programs like Medicare.⁷⁷ If physicians in a wholesaler-owned practice receive financial benefits—directly or indirectly—tied to prescribing drugs distributed or favored by the wholesaler, the arrangement could be deemed an illegal kickback scheme.⁷⁹ The Physician Self-Referral Law (Stark Law) and medical ethics codes also strictly prohibit financial relationships that could compromise a physician's objective medical judgment.⁷⁸

Impact on Physician Autonomy and Patient Care

The most significant risk of this trend is its potential to erode physician autonomy and

subordinate patient care to corporate financial interests.⁷⁵ A large body of research demonstrates that financial relationships between physicians and the pharmaceutical industry influence prescribing behavior, often leading to increased use of more expensive, promoted drugs.⁸² By creating an employment relationship, wholesalers can exert a much more direct and powerful influence than traditional marketing. For patients, the consequences could include higher costs, reduced access to the most appropriate medications, and a loss of trust in a healthcare system where clinical decisions may be driven by the profit motives of a distributor rather than by their own health needs.⁷²

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U.S. SENATE SPECIAL COMMITTEE ON AGING

"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS"

OCTOBER 22, 2025

STATEMENTS FOR THE RECORD

American Hospital Association (AHA) Statement

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, as well our clinician partners - including more than 270,000 affiliated physicians, two million nurses and other caregivers - the American Hospital Association (AHA) appreciates the opportunity to submit this statement to share the hospital field's comments on how to reduce health care costs for seniors.

OVERVIEW OF NATIONAL HEALTH SPENDING

America's hospitals and health systems understand and share your concerns regarding the high cost of health care. Hospitals continue to face a perfect storm of financial pressures driven by persistent cost growth, inadequate reimbursement and shifting care patterns driven by both policy changes and an older, sicker population with more complex, chronic conditions. Despite escalating expenses, Medicare reimbursement continues to significantly lag behind inflation. At the same time, the practices of certain Medicare Advantage (MA) plans to increase delays, denials and underpayments are exacerbating the financial burden faced by hospitals. These challenges create significant barriers to hospitals' ability to continue to provide access to essential services and care, especially for our nation's seniors.

Rising prescription drug prices also continue to be a major cost driver for both patients and hospitals and health systems. Average drug expenses per patient increased nearly 20% between 2019 and 2022.¹ In addition, a government report found that drug companies increased prices faster than inflation for approximately 2,000 drugs between January 2022 and January 2023, with an average price increase of 15.2%.² Compounding this problem are decisions made by drug companies to price new drugs coming onto the market at record-high levels, with the median price of a new drug in 2023 costing \$300,000 and increasing to \$370,000 in 2024.^{3,4}

HOSPITAL PRICE TRANSPARENCY REQUIREMENTS

We appreciate Congress' ongoing interest in hospital price transparency to provide consumers with access to the price information they need, which is specific to their course of treatment.

Hospitals and health systems must comply with both state and federal price transparency policies, which include the federal Hospital Price Transparency Rule and provisions in the No Surprises Act. The Centers for Medicare & Medicaid Services (CMS) monitors hospital price transparency compliance, which includes requirements for a consumer-friendly display of shoppable services information, as well as comprehensive, machine-readable files. Since the Hospital Price Transparency requirements went into effect in 2021, hospitals have invested countless staff hours and substantial resources in adhering to the provisions and remain committed to ensuring they meet the regulatory requirements, even as the provisions have been continually modified since implementation.

We are concerned with legislative proposals that would diverge from current regulatory requirements and impose additional administrative burdens on hospitals and health systems. For example, provisions have been drafted that would no longer recognize price estimator tools as a method to meet the shoppable services requirement under the Hospital Price Transparency regulations. This change would both reduce access to a consumer-friendly research tool and unfairly penalize hospitals that have spent significant capital to comply with the regulation.

Price estimator tools offer consumers an estimate of their out-of-pocket costs based on their insurance benefit design, such as cost-sharing requirements and prior utilization, as well as the patient's annual deductible. This is an important feature

¹ <https://www.aha.org/system/files/media/file/2025/04/The-Cost-of-Caring-April-2025.pdf>

² <https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs>

³ <https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-rose-35-2023-more-than-previous-year-2024-02-23/>

⁴ <https://www.reuters.com/business/healthcare-pharmaceuticals/prices-new-us-drugs-doubled-4-years-focus-rare-disease-grows-2025-05-22/>

of these tools that is not available from a shoppable services spreadsheet. Eliminating the use of price estimator tools as a method to meet the shoppable services requirement of the Hospital Price Transparency Rule would therefore reduce price transparency for patients. We urge Congress to reject this potential change.

As Congress seeks to make statutory changes to price transparency standards, it is important for legislators to consider the adjustments that CMS regularly makes to the Hospital Price Transparency Rule. These include changes related to standardization, new data elements, file accessibility, and the accuracy and completeness affirmation, as well as changes to CMS' monitoring and enforcement processes. CMS currently requires hospitals to use a standard format to comply with the machine-readable file requirement, which includes data elements such as negotiated rate contracting type or methodology, an accuracy and completeness affirmation, and (as of Jan. 1, 2025) an "estimated allowed amount."

CMS also requires that hospitals' price transparency information be more easily found on their websites. In the calendar year 2026 outpatient prospective payment system proposed rule, CMS considered drastically changing these requirements once again, both in terms of the required data elements in the machine-readable files and the attestation language. Should Congress pass price transparency legislation that does not align with current requirements or the new requirements expected to be finalized in the coming months, it would negate the work that CMS has done to update the rule based on lessons learned since the regulation took effect.

Regarding compliance and enforcement, hospitals may be required to have an authorized hospital official certify the accuracy and completeness of the hospital's machine-readable file during the monitoring and enforcement process. CMS can also require hospitals to provide additional documentation at the agency's request, including contracting documentation needed to validate the hospital's negotiated rates and verification of the hospital's licensing status.

CMS publicizes hospital-specific information on all compliance assessment and enforcement activity, which it now updates regularly on a public website. This includes details related to CMS' assessment of hospital compliance, any compliance actions taken against a specific hospital, the status of the compliance action(s) and the outcome of the action(s). Since the hospital price transparency requirements took effect in 2021, CMS has changed the requirements and guidance several times. While many of these changes have made expectations clearer and easier to comply with, their repeated implementation requires significant time and resources.

Hospitals and health systems are eager to continue working towards providing the best possible price estimates for their patients.

The AHA asks Congress to take the following steps to support these efforts:

- Review and streamline the existing transparency policies with a priority objective of reducing potential patient confusion and unnecessary regulatory burden on providers.
- Focus efforts on ensuring pre-service estimates can be as accurate as possible, including by simplifying benefit design.
- Continue to convene patients, providers and payers to seek input on how to make federal price transparency policies as patient-centered as possible.
- Refrain from advancing additional legislation or regulations that may further confuse or complicate providers' ability to provide meaningful price estimates while adding unnecessary costs to the health care system.

REJECT SITE-NEUTRAL PAYMENT CUTS

The AHA strongly opposes efforts to expand site-neutral payment cuts, which would jeopardize access to care for seniors. Current Medicare payment rates appropriately recognize that there are fundamental differences between patient care delivered at hospital outpatient departments (HOPDs) compared to other settings. HOPDs treat patients who are more likely to be sicker and more medically complex while also being held to stricter patient safety standards and regulatory requirements.

This is especially true in rural communities. Medicare beneficiaries in rural areas - including those who are dually eligible for Medicaid - disproportionately rely on HOPDs to meet their increased health care needs since they have less access to office-based physicians.⁵ Additional Medicare cuts to these facilities will have a direct impact on the level of care and services available to patients in rural communities.

The cost of care delivered in HOPDs accounts for the unique benefits that hospitals and health systems provide to their communities - which are not provided by

⁵ <https://www.aha.org/system/files/media/file/2024/01/analysis-hospitals-health-systems-are-critical-to-preserving-access-to-care-for-rural-communities-report.pdf>

other sites of care. This includes investments made to maintain standby capacity for natural and manmade disasters, public health emergencies and unexpected traumatic events, as well as delivering 24/7 emergency care to all who come to the hospital.

Existing site-neutral payment cuts have already created significant financial challenges for many hospitals and health systems. This is largely because Medicare significantly underpays hospitals for the cost of caring for patients. The latest analysis, from 2023, shows that on average, Medicare paid only 83 cents for every dollar spent by hospitals, resulting in over \$100 billion in underpayments.⁶

The AHA urges Congress to reject any additional site-neutral cuts, which would exacerbate the financial challenges facing hospitals and health systems and reduce access to essential care for Medicare beneficiaries, especially those living in rural and underserved communities.

CONCLUSION

Thank you for your consideration of the AHA's comments on issues related to reducing health care costs for seniors. We look forward to working together to ensure patients continue to have access to quality care in their communities.

⁶<https://www.aha.org/system/files/media/file/2025/04/The-Cost-of-Caring-April-2025.pdf>

U.S. SENATE SPECIAL COMMITTEE ON AGING

"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS"

OCTOBER 22, 2025

STATEMENTS FOR THE RECORD

Families USA Statement

Chair Scott and Ranking Member Gillibrand, we want to thank you for holding this important and timely hearing on health care affordability, and to offer our sincere appreciation to all of the witnesses and senators who are lifting up the impact that unaffordable health care costs have on our nation's families, especially older adults.

Across the country, Americans are sounding the alarm: the cost of health care is too high, the system too complex, and relief is desperately needed. In 2025, nearly half of all Americans struggle to afford the health care that they and their families need due to the high cost.¹ More than a quarter of older Americans, who spend more on health care than any other age group, report being very concerned they will be unable to pay for lifesaving health care in the future.² Even families with commercial coverage are spending up to 25% of their monthly budget on health care costs.³ These high costs have left 100 million families grappling with medical debt they may never pay off.⁴

Rising health care costs stem from a fundamental misalignment between the business interests of the health care sector - including big drug companies, corporate hospital systems, pharmacy benefit managers (PBMs), and insurers - and the health and financial security of our nation's families. The unchecked growth of big health care corporations and a lack of oversight over their business practices have led to monopolistic health care practices and prices, reduced access to care, worse health outcomes, and lower wages for workers. Health care industry players charge excessive health care prices and take advantage of loopholes that drive inefficient health care spending that has little to do with the quality of care patients receive. This was all true before recent policy changes like the passage of H.R. 1, which cuts \$1 trillion from our health care system, compounding this crisis by limiting access to affordable care while failing to provide families with relief from high health care costs.

It's time to put partisanship aside and provide Americans with desperately needed relief from crushing health care costs. Congress must take immediate steps to support families whose health and financial security are in jeopardy, while also committing to address the root causes of our nation's health care cost crisis by taking on price gouging by corporate health systems. The first step is for Congress to come together to extend enhanced premium tax credits for the nearly 22 million Americans who rely on them to help them afford comprehensive health coverage from the federal or state health insurance Marketplaces.⁵ If Congress fails to prevent these key tax credits from expiring this year, millions of Americans will see their health

¹ KFF, Americans' Challenges with Health Care Costs, July 11, 2025. <https://www.kff.org/health-costs/issuebrief/americans-challenges-with-health-care-costs/>

² Nicole Willcoxon, Older Adults Sacrificing Basic Needs Due to Healthcare Costs, June 15, 2022. Gallup, Inc. <https://news.gallup.com/poll/393494/older-adults-sacrificing-basic-needs-due-healthcare-costs.aspx>; Centers for Medicare and Medicaid Services, National Health Expenditure Data, U.S. Personal Health Care Spending By Age and Sex 2020 Highlights. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/national-health-expenditure-data/downloads/age-and-gender-highlights.pdf>

³ Sara R. Collins, Shreya Roy, and Relebohile Masitha, "Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer: Findings From the Commonwealth Fund 2023 Health Care Affordability Survey," The Commonwealth Fund, October 26, 2023, <https://doi.org/10.26099/bf08-3735>.

⁴ Noam N. Levey, "100 Million People in America Are Saddled With Health Care Debt," KFF Health News, June 16, 2022, <https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/>.

⁵ Centers for Medicare & Medicaid Services, "2025 Marketplace Open Enrollment Period Public Use Files." May 12, 2025. <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>.

insurance premiumsskyrocket next year - more than double on average,⁶ with many paying not just hundreds butthousands of dollars more for health coverage - and roughly four million people will lose coveragealtogether.⁷

The Aging Committee has a key role to play in discussing and advancing bipartisan andcommonsense legislation that would remedy some of the most obvious health system failings, andthe American people are eager to see action. A new poll from Families USA and Hart ResearchAssociates shows that lowering health care costs is the top priority for Americans acrossdemographics, even surpassing concerns related to housing, jobs, crime, and immigration. Over 9in 10 voters think it is important that Congress and the President act to lower health carecosts to reduce stress on family budgets, bring down the cost of living, and to make healthcare more affordable and accessible to millions of families around the country.⁸

Congress Must Act Now to Make Health Care Tax Credits Permanent

A top priority for this Committee and your colleagues in Congress must be to permanently extend the expiring enhanced premium tax credits to ensure millions of people can continue to afford their health insurance. Millions of American workers who don't get coverage on-the-job or through Medicaid or Medicare qualify for premium tax credits for a plan on healthcare.gov or a state marketplace if their current household income is at least \$15,060 for an individual or \$31,200 for a family of four, and they do not have other options for affordable health coverage.⁹ If Congress does not intervene, these individuals and families will enter the annual open enrollment period for health coverage on November 1 and be hit with premiums that may be double or triple what they paid last year, with no guarantee that any tax credit relief will be available to them later. The effect on families, communities, and local economies will be devastating.

These tax credits are a lifeline for workers and their families, including those with serious andchronic health conditions like diabetes, heart disease, and cancer who need access to regular care to stay healthy and keep working when they don't get insurance through their job. If Congress failsto act, older adults would be some of the hardest hit. For example, a couple in their early 60searning a combined income of \$90,000 will see their premiums spike by more than 250% - awhopping increase of more than \$26,000 per year. In some states, their premiums will increase byover \$50,000.¹⁰

The enhanced premium tax credits have been lifechanging for people like Amy from New Castle,Colorado who runs a small print publishing business with her husband that garners a householdannual income of about \$40,000. While her husband is covered by Medicare, Amy relies on themarketplace for the health insurance she needs to manage her chronic health condition. Utilizingenhanced premium tax credits, her monthly premiums dropped from a staggering \$923 to just\$1.57 each month. Only with these credits can Amy get the coverage she needs to stay healthy,keep their small business open, and contribute to the local economy.¹¹

⁶Andrew Sprung. "Trump administration takes one more whack at the ACA marketplace." Xpostfactoid. September 4, 2025. <https://xpostfactoid.substack.com/p/trump-administration-takes-one-more>

⁷Congressional Budget Office, The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums, December 4, 2024. <https://www.cbo.gov/system/files/202412/59230-ARPA.pdf>.

⁸Families USA, "New Poll: Crushing Health Care Costs Top Priority for Voters" October 22, 2025. <https://familiesusa.org/press-releases/new-poll-crushing-health-care-costs-top-priority-for-voters/>

⁹"Advance premium tax credit (APTC)," HealthCare.gov, U.S. Centers for Medicare & Medicaid Services, accessed July 25, 2025. <https://www.healthcare.gov/glossary/advanced-premiumtax-credit/> and 2024 federal poverty guidelines, <https://aspe.hhs.gov/sites/default/files/documents/7240229f28375f54435c5b83a3764cd1/detailedguidelines-2024.pdf>. The minimum income limits are slightly higher in Alaska and Hawaii due to those states' poverty guidelines. The income limits will increase slightly for 2026 - people may qualify then if their incomes their incomes are above 2025 federal poverty guidelines, listed here: <https://aspe.hhs.gov/sites/default/files/documents/dd73d4f0d8a819d10b2fdb70d254f7b/detailedguidelines-2025.pdf>

¹⁰Cheryl Fisch-Parcham, "Health Premiums To Spike for American Workers and Small Business Owners If Enhanced Health Care Tax Credits Are Not Made Permanent" Families USA <https://familiesusa.org/wpcontent/uploads/2025/10/National-ImportancePremiumTaxCredits-Fact-Sheet-October-2025-Update.pdf>

¹¹Lauren Rubenstein, "Behind the Numbers: The Real Americans who will be Hardest Hit if Congress Lets Premium Tax Credits Expire" Families USA, September 25, 2025 <https://familiesusa.org/resources/behindthe-numbers-the-real-americans-who-will-be-hardest-hit-if-congress-lets-premium-tax-credits-expire/>

Amy needs Congress to take immediate action, and she isn't alone: Roughly three-quarters of Americans polled from across the country - and across party lines - want Congress to act to extend the enhanced credits.¹²

Committing to an Agenda that Addresses Root Causes of High Health Costs

Beyond providing immediate relief and certainty to families and older adults who utilize the enhanced premium supports, this Committee and your colleagues in Congress have an important opportunity and responsibility to take on the corporate interests and underlying drivers of high health care costs and advance pro-consumer reforms to the health care system that put money back in people's pockets. To that end, almost all of below priorities have bipartisan and bicameral support in Congress and would make important strides to begin addressing corporate abuses in health care, and our new poll shows that voters across the political spectrum believe these bold actions will be most effective at immediately bringing down costs:¹³

- Requiring all hospitals to disclose rates they charge in dollars and cents (91% support),
 - Prohibiting health systems from charging Medicare more for the same procedure if performed at a hospital facility instead of a doctor's office (84% support),
 - Prohibiting Medicare Advantage companies from exaggerating health risks to get paid more (79% support),
 - Eliminating legal loopholes that allow health care providers to overcharge (75% support),
 - Restricting aggressive billing practices like surprise billing (73% support),
 - Reducing unnecessary middlemen between patients and providers, who increase costs (72%),
 - Closing legal loopholes that allow drug companies to raise prices by blocking generics (87% support),
 - Allowing Medicare to negotiate lower prices on more drugs (89% support),
- and
- Reforming the way doctors and providers are paid, so pay is based on keeping people healthy and quality of care rather than the number of procedures (80% support).

Thank you again for holding this timely and critical hearing. Now, more than ever, families across the country are feeling the negative impacts of our nation's affordability crisis firsthand and are eager for Congress to pass legislation that provides meaningful relief and reaffirms that their elected representatives are doing all they can to deliver on their promises to lower costs and improve health care. The journey to fully transform our health care system so that it truly works for American families is long, but Congress holds the power to take the next critical steps. FamiliesUSA stands ready to support you in this essential and urgently needed work.

¹²Families USA, "New Poll: Crushing Health Care Costs Top Priority for Voters" October 22, 2025, <https://familiesusa.org/press-releases/new-poll-crushing-health-care-costs-top-priority-for-voters/>

¹³Families USA, "New Poll: Crushing Health Care Costs Top Priority for Voters" October 22, 2025, <https://familiesusa.org/press-releases/new-poll-crushing-health-care-costs-top-priority-for-voters/>

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Federation of American Hospitals Statement

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the Senate Special Committee on Aging hearing on "Modernizing Health Care: How Shoppable Services Improve Outcomes and Lower Costs." As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, we strongly support efforts to improve health care transparency and empower patients with actionable information. Hospitals have been committed partners in implementing federal price transparency requirements, investing significant resources to comply with evolving regulations issued by the Centers for Medicare & Medicaid Services (CMS).

The FAH supports the goal of ensuring that patients have access to clear, accurate and actionable cost-sharing information. Providing this information empowers patients to make more informed decisions about their health care. Since the issuance of the 2019 Executive Order on price transparency, hospitals have undertaken a vast modernization effort to make pricing more accessible and understandable for patients. This effort has evolved from posting gross charges to publishing complex, standardized data files that detail negotiated rates with insurers, discounted cash prices, and estimated allowed amounts in a usable format. Further, our members have developed price estimator tools to help patients plan for their care and expanded resources to connect families with financial assistance programs. These advances have required significant new investments in staff, technology, and vendor support. While CMS initially projected hospitals would spend roughly \$250 million on compliance from 2020 to 2025, actual investments have far exceeded that figure-particularly for hospitals that stepped up early to meet changing federal rules and lead the way on transparency.

We appreciate the current Administration's results-oriented approach and active engagement with hospitals when it comes to compliance with transparency regulations. FAH members report that CMS is expeditiously closing enforcement actions when an appropriate corrective action plan has been initiated and completed. Some of these enforcement matters involve simple issues like unexpected website glitches, and CMS' approach to these cases has ensured that access to a compliant machine-readable file is restored quickly through a cooperative enforcement process. The current enforcement approach also maximizes compliance by including critical opportunities for education. In particular, initial warning letters have opened up cooperative dialogue between hospitals and CMS that allow both to develop a more sophisticated understanding of hospital pricing and price transparency. This process also provides the most expeditious path to promptly resolve minor and inadvertent issues with machine-readable files. The FAH recommends maintaining the current orientation toward education and impactful results in monitoring and enforcement activities.

Given the significant progress hospitals have already made-and with new federal transparency requirements taking effect on January 1, 2025-the FAH urges policymakers to support a period of regulatory stability. Constantly changing rules create unnecessary costs and administrative burdens that pull resources away from patient care, without meaningfully improving the information patients receive. Stability will allow hospitals to strengthen existing systems, enhance data accuracy, and make the most of the substantial investments they have already made-all while confronting financial pressures, cybersecurity risks, and the growing costs of caring for the uninsured.

The FAH also calls on Congress and CMS to bring balance to transparency efforts by ensuring that health plans meet the same high standards now expected of hospitals. The Transparency in Coverage Rule was designed to provide a full picture of health care pricing, but enforcement and oversight of payer data have fallen behind. Modernizing these requirements-so that payer data is complete, accurate, and includes qualifying payment amounts under the No Surprises Act-is critical to achieving our shared goal of promoting transparency and shoppability. A balanced

approach that includes both providers and payers is in the best interest of patients, employers, and taxpayers.

Hospitals have not just complied with transparency regulations-our members have built the infrastructure that makes price transparency real for patients. We look forward to working with Congress to ensure the successful implementation of transparency measures across the health care system.

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New York State of Health Statement

The following stories came from consumer emails in reaction to recent announcements regarding the impact of H.R. 1. on health coverage:

1) Trump is an absolute terror and my heart breaks for the people who are going to suffer because of what he is doing. Republicans have blood on their hands. I am praying that I can figure out an affordable solution to pay for health insurance-I have a chronic condition that requires a lot of meds and testing, so people like me are being disproportionately affected by this change. Shame on the GOP-I am devastated.

2) New York State has been a leader in expanding healthcare access. I hope that leadership will continue in the form of sustained resistance to federal policies that undermine the health and wellbeing of your residents. Thank you for accepting and considering these comments.

3) Only since the Affordable Care Act have I been able to get all the things I need as a type 1 diabetic. Only since the Affordable Care Act have I even been able to be covered by health insurance. Because of my "pre-existing condition" that I was born with; I could never get coverage before. It is complete and utter bullshit that millions of other Americans and I have to suffer because of the greed and ruthlessness of the federal government. Profit over patients; it's sickening. I want to personally thank Donald Trump and his puppets for the possible death sentence for myself and millions of others.

4) Please stand up to this authoritarian administration. Especially those living with HIV in this country. What are we supposed to do without coverage? Just die? We're forced to pay high monthly premiums for nothing and now literally nothing. Where's the empathy? This is NYC! Don't let the people that actually pay taxes for the city be the ones to suffer. None of this makes sense.

5) I recently received an email stating that I would be losing my NYS Essential Plan Health Insurance due to cuts at the federal level. This is extremely disheartening as I have spent the last year battling stage three cancer. The Essential Plan has saved my life as I would not have been able to pay the over a million dollars in costs for chemotherapy, radiation, and surgery. I am 47 years old, a single mother of four with some in college, hold a masters degree, and work full time as an Executive Director of a Not for Profit. I am very concerned for my health moving forward and how my family will be affected by my difficulties in paying for health insurance and doctor's bills. I hope that there is something that can be done to save this critical health insurance for New Yorkers.

6) I have been covered under the United Healthcare Essential Plan which has been a Godsend to me and my family. We have been able to receive the care we need since the ACA Act was implemented. We just received the email about the changes to this plan and it is incomprehensible. The Federal Government should want to help people, not harm them.

7) It is my understanding that these cuts are being implemented to fund tax cuts for the top 1% in this country. It makes no sense. Why do they want to punish people who are already struggling? Food prices are higher than ever. People are being laid off left and right. We see the Democrats are doing their best to bring Republicans to the table for precisely this issue. We support them and hope this can be resolved. Cutting healthcare subsidies for working people is not the answer. We thank you for all you do, and we hope this horrifying new policy can be reversed.

8) I've been on the Essential plan for years, and I depend on my health insurance for daily medication, frequent appointments and procedures. I'm a New Yorker that has worked full time since I was 19 and still can't get ahead in life. I have multiple health concerns, including an auto immune disease. It makes me sick to think my coverage is ending because the president wants to play with the money. This is completely unacceptable and will likely result in people dying. This needs to be corrected. I can't afford to see my doctors (yes multiple) without insurance and my employer plan is completely unaffordable. What am I supposed to do? Come July I'm

just out of coverage with no options? This is absolutely sickening. Do better NY. Trump is running this country.

9) I've just received an email stating that as of July 1, 2026, I will no longer be covered by the Essential Plan in NY. I am incredibly upset and frustrated that the political games being played by US Senate and House Republicans at the behest of convicted felon and adjudicated rapist Donald Trump, and his advisors and authors of Project 2025, such as Stephen Miller, who have no regard for the general public and the citizens of this country whom they are supposed to protect, will now result in myself and many, many other New Yorkers losing their health care. I work two part-time jobs, neither of which offers benefits or health care, and cannot afford to pay for monthly health care premiums offered by the New York State of Health program. You can't pull blood from a stone, and I can't magically make money appear that doesn't exist in my paychecks. I need NY State, and our duly elected officials who are meant to be working FOR US, the citizens who elected them, to find a way to fix this, whether it be by passing a new healthcare plan, or repealing Trump's "Big Beautiful Bill" which is neither big, nor beautiful, and restoring my proper healthcare. I am on medications for life, which I will not be able to afford to pay for without insurance, and I am frankly absolutely disgusted with the state of our elected representatives and their incredibly obvious lack of care about who they see as their "enemies." Something needs to be done, and I can promise you on my part, I will never be voting for anybody affiliated with the Republican Party ever again, as they clearly do not consider me and all those like me to be worth helping. I can also promise you that I will not ever again be voting for anyone affiliated with the Democratic Party who does not fight for my rights.

10) I will likely be one of the New Yorkers impacted. For the purposes of this comment, I strongly prefer to remain anonymous. The changes due to H.R.1 feel personal. I can't help but feel that it is as though America is turning its back on the poor. When I initially qualified for Medicaid, I was very thankful, but I also didn't want to "abuse" the system, so I've kept my use to the absolute minimum, preventative appointments only. I try to keep well so that I don't pull on an already burdened system. Still, the results of the election sent a message. The message is that the majority of Americans are not happy with people like me-- who are not fully qualified for disability and also do not feel well enough to work. We are already poor. It doesn't feel right that we are also now kicked off of our medical insurance. Also, I would like to point out that many other social support systems are tied to Medicaid eligibility: rides to medical appointments, eligibility for food pantries, and discounted shopping services. I'm facing losing all of this. I realize that NY is doing all it can and I appreciate that. I'm not against the Basic Health Plan but I don't think I'll be able to benefit as I'm not part of the "working" NY. I believe it when I hear that my Governor is trying to work for New Yorkers. I truly believe she would listen if I described the difficult situation that I'm facing, but I find all of this disappointing. Where is the kindness to the poor that New York is known for? I pray that we will weather this storm.

11) Well, we all know how shitty Donald Trump is being but this one takes it. Costing all of the poor-middle class ranged Americans their health insurance, so he can continue to get richer since he went bankrupt so many times. Now....we all have to pay for it. I can't afford the ridiculous costs of health insurance this is going to cost me.

12) Do I pay to be healthy and have coverage or feed my family, is what this comes down to. I'm always going to choose my family. So now, if I go to the doctor for my hemiplegic migraines or my diabetes or need emergency care, I'll have to pay even MORE out of pocket because I don't have healthcare because I can't afford the monthly premiums. MAKE AMERICA GREAT AGAIN! Let me know when this happens.

13) We need to stand up to Trump and his disgusting administration by sticking UP for New Yorkers. We are not like that. We do not abandon our neighbors. We need to find a way. New Yorkers will not forget. If we're left to suffer we will remember, but if we are supported, we will remember that too. Which do you prefer? I'm so proud to live in New York, this is breaking my heart and spirit. Please reconsider terminating the 1332 waiver. Please.

14) I am submitting this comment in response to New York State's request for public input on the forced termination of Essential Plan coverage due to federal policy changes. As someone whose coverage will end on July 1, 2026, I want New York State officials to understand the very real impact this decision will have on working New Yorkers who have relied on this program.

I am a small business owner who relocated from Florida to New York City specifically to build my practice and life in a state that demonstrated a genuine commitment to healthcare access. The Essential Plan has been essential to my ability to

operate my business while maintaining the health security that allows me to serve my clients and contribute to New York's economy. That decision to move here now feels undermined by federal policymakers who appear indifferent to the needs of working people.

My academic training, which culminated in a PhD, taught me to evaluate policy through evidence and impact. The evidence here is clear: terminating coverage for individuals who qualify for and depend on this program will result in worse health outcomes, increased financial stress, and decreased economic stability for thousands of New York families.

I understand that New York State did not choose this outcome and is being forced to implement a federal decision that contradicts our state's values and priorities. I appreciate that the state is providing advance notice and has committed to supporting affected individuals through this transition. However, I want to emphasize how inadequate any transition will be when the end result is a loss of comprehensive, affordable coverage.

The federal government's characterization of this decision as "deeply unfortunate" does not capture what it means for people like me. It means anxiety about whether I can afford the healthcare I need. It means uncertainty about whether an unforeseen health-related issue would bankrupt me. It means questioning whether I made the right choice in building my life and business in New York when the federal government can arbitrarily strip away the healthcare access that made that choice viable.

I urge New York State officials to:

- Advocate forcefully at the federal level for reversal of this policy decision.
- Explore every possible state-level option to maintain coverage or provide comparable alternatives.
- Ensure that any transition process prioritizes continuity of care for individuals managing serious health conditions.
- Continue to publicly document and communicate the harm this federal decision causes to New Yorkers.

15) The fight in Congress over the Republicans plan to discontinue the tax credits for ACA premiums must continue. Premium tax credits make health insurance accessible for millions of U.S. citizens. Without the tax credits, cost of premiums will skyrocket, rendering health insurance inaccessible for millions. Make no mistake - access to health insurance directly equates to access to healthcare. Healthcare costs in the U.S. are astronomical and would very easily bankrupt millions of average U.S. households.

The ACA allows citizens who have no access to group insurance plans through their employment, access to insurance. This includes the self-employed, contract/sole proprietors (a fast-growing number of workers since online work has become so popular with companies and workers), freelance workers, and less than full-time W2 employees.

I am a self-employed, private practice psychotherapist. I worked long and hard to earn a master's degree at one of the nation's top universities. I do not have access to group insurance because I am a solo practice clinician. Although I am incorporated, group insurance plans for companies require two or more employees. Even though my spouse does a great deal of administration for my business, spouses are disqualified from counting towards that minimum. He is a contract employee/sole proprietor, so he has no employer-based health insurance. Therefore, the ONLY access to health insurance we have is the ACA.

NOTE: When workers have health insurance through their employers, the employer pays a share. Additionally, premiums are paid PRE-tax. Self-employed/small business owners do not get these benefits. Premiums are paid fully out-of-pocket POST-tax. Furthermore, premiums do not count as out-of-pocket healthcare costs, so we are unable to claim them as an expense on our federal taxes. This is truly unfortunate, since average health insurance premiums can easily be \$1000/month or more and would meet the 7.5% of total income to qualify as an itemized deduction on our federal taxes.

So, in summary, the thinly veiled excuse used by Republicans, that those needing ACA premium tax credits are looking for "a handout" or want to "get something for free" is not only incredibly insulting, but wholly untrue. Also, the indisputable lie being propagated by the Trump administration and right wing/propaganda media outlets that undocumented/illegal immigrants can get insurance through the ACA (or Medicaid) needs to be loudly and adamantly disputed and disproved. This needs to happen every day until their disinformation and propaganda messaging is shown for what it is - an outright lie.

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Purchaser Business Group on Health Statement

The Purchaser Business Group on Health ("PBGH") applauds the committee for holding this timely hearing on the most pressing issue in health care: Affordability. Our members (one of whom is an expert witness during today's hearing) agree. Cost control and affordability emerged as the top issue for large employers and public purchasers in PBGH's 2025 Annual Survey⁽¹⁾ against a backdrop of escalating costs⁽²⁾ and growing fiduciary risk.⁽³⁾

We agree with the premise of this hearing, which is that while policy debates typically center around the problems of our health care system, we ought to focus primarily on the solutions. PBGH and our members have developed thoughtful policy solutions⁽⁴⁾ - informed by the real-world experience of purchasers - to improve America's health care system, including:

- Strengthening and codifying the Administration's two price transparency rules and ensuring purchasers have full access to their health care claims data under federal law.

- Prohibiting anticompetitive contracting practices in the health care industry, which limit purchasers' ability to direct contract, develop and use high performance networks, or implement reference pricing strategies that leverage independent sources of price data.¹

- Removing barriers to direct contracting for medical services, so purchasers can exercise their buy-side market power to help employees shop for high-quality, fairly priced care.

- Supporting direct/advanced primary care, to improve patient access to valuable preventive services and ensure that patients are appropriately referred to high-quality, fairly priced specialist care through the unconflicted advice of their trusted primary care physician.

- Scrutinizing the role intermediaries (i.e., PBMs, TPAs) play in driving health care costs up.

- Reforming policies that directly or indirectly contribute to consolidation in health care markets, which lessens choice and leads to higher prices without gains in quality. In addition to these policy solutions, PBGH has been deeply engaged in supporting employers to use the price transparency data to lower their health care costs and improve health outcomes.

In addition to these policy solutions, PBGH has been deeply engaged in supporting employers to use the price transparency data to lower their health care costs and improve health outcomes.

The PBGH Health Care Data Demonstration Project

PBGH and our purchaser members have been at the forefront of using the data made available under the Hospital Price Transparency ("HPT") Rule as well as the Transparency in Coverage ("TiC") Rule with a first-of-its-kind data demonstration project.⁽⁵⁾ In January 2025, PBGH announced the deployment of this initiative, which aggregates and analyzes the de-identified claims and demographic data from five large purchasers across 10 regional markets alongside the price transparency datasets. Through partnerships with Milliman, Embold, and Leapfrog, we also integrated individual provider quality metrics and hospital safety scores, as high quality of care is a top priority for our purchaser members.

¹Traditionally, the prevailing reference for health care service pricing information has been Medicare's reimbursement rate, such that purchasers' reference pricing strategies have benchmarked to a multiple of Medicare (e.g., 150 or 200%). However, since hospitals and insurers were required to publish their negotiated rates publicly, it is now also possible for purchasers to compare the prices they are paying for health care services to the market rates for those services that have been negotiated and agreed to between health care providers and payers / other purchasers.

This demonstration project has delivered important insights to purchasers on how the prices they pay compare to the market and what network selection and benefit design opportunities exist. The findings of this project are being used now by the participating purchasers to:

- Determine what fair prices for health care services are in their regional market and assess one's own costs and quality against other networks in the market.
- Identify high quality clinicians to develop Centers of Excellence, design high performance networks, and steer employees to high-quality, fairly priced providers.
- Validate existing direct contracting relationships as well as identify opportunities for new direct contracts.
- Hold service provider partners accountable for competitive prices/rates, contractual performance guarantees, and full compliance with federal price transparency rules.

The results of this first iteration of PBGH's demonstration project were recently released to the public on September 24, 2025⁽⁶⁾ and were announced via press release on October 16, 2025.⁽⁷⁾ As a sign of our commitment to supporting this Committee in its important work to improve health care affordability and health outcomes, we are enclosing a copy of the PBGH whitepaper "Leveraging Health Care Price Transparency," which details the findings, market implications, and policy implications of the initial phase of the project.

PBGH sincerely appreciates the Committee's attention and dedication to advancing policies that improve health care affordability and outcomes, and which facilitate purchasers' ability to achieve these objectives on behalf of America's workforce.

Sincerely,

/s/

Elizabeth Mitchell, President and CEO
Purchaser Business Group on Health

ENDNOTES

- (1) PBGH (May 13, 2025) "PBGH Announces Jumbo Employers' Top 5 Health Care Priorities" Announcement [Link]
- (2) Mitchell (Jul. 2, 2025) "Want to Lower the Price of Eggs? Start with Health Care Costs" US News & World Report [Link]
- (3) PBGH (Mar. 31, 2025) "Purchaser Innovation and Policy Engagement Against a Backdrop of Unaffordability and Fiduciary Risk" Issue Brief [Link]
- (4) PBGH (Jan. 31, 2025) "Purchaser Policy Priorities in 2025" Issue Brief [Link]
- (5) PBGH (Jan. 29, 2025) "PBGH Launches Groundbreaking Health Care Data Project, Tackling Data Transparency Challenges and Strengthening Employer Fiduciary Compliance" Announcements [Link]
- (6) PBGH "Are We There Yet? Making Transparency Work for Purchasers and Patients" Webinar [Link]
- (7) PBGH (Oct. 16, 2025) "PBGH Unveils Breakthrough Data Demonstration Project, Empowers Employers to Expose Hidden Costs and Hold Vendors Accountable" Press Release [Link]

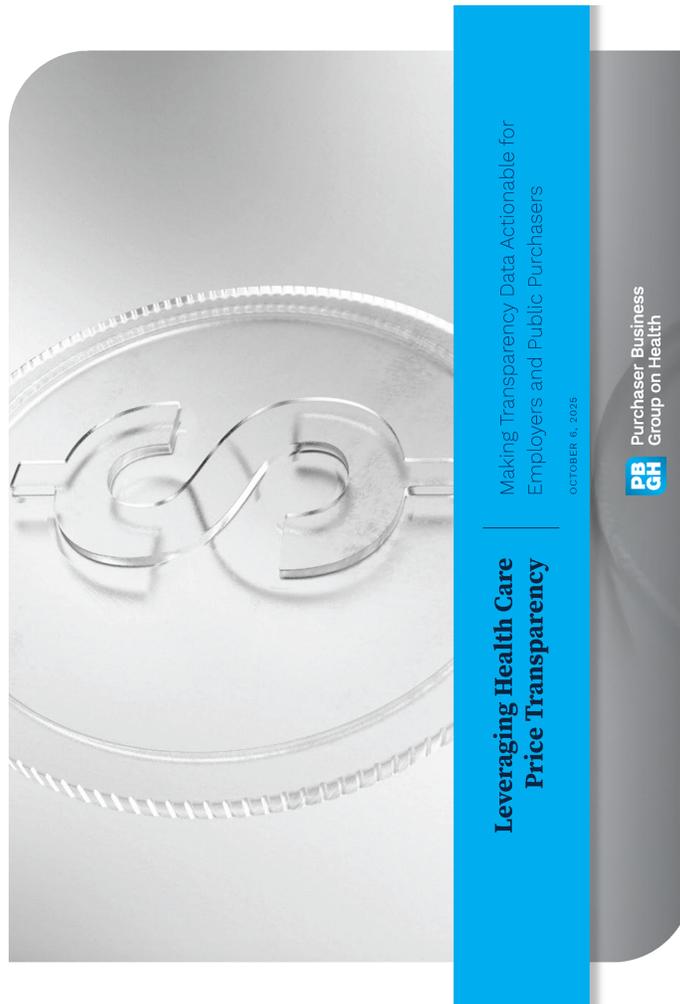
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Purchaser Business Group on Health: Leveraging Health Care Statement



Leveraging Health Care Price Transparency

Making Transparency Data
Actionable for Purchasers

A purchaser-driven analysis combining hospital and payer pricing data with transparency data and quality metrics reveals trends from a current transparency regulation for health care purchasers and the areas of opportunity for policymakers.



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1. Introduction

The Purchaser Business Group on Health's ("PBGH") Health Care Data Demonstration Project is the first large-scale, purchaser-driven effort to open the black box of U.S. health care spending using transparent price data. By aggregating and analyzing millions of claims, transparency data, and quality data across markets, this initiative provides an unprecedented, independent view into how prices, utilization, and outcomes vary; and where purchasers and patients are paying more without getting more. This project is uniquely designed to hold the players in our health care system accountable and give purchasers the evidence they need to identify inefficiencies, challenge market power, and advocate for policy reforms that deliver real value for patients and purchasers alike.

Federal price transparency rules implemented in 2021 and 2022¹ promised to illuminate a \$4.9 trillion industry where prices are hidden until after care is delivered. The Hospital Price Transparency ("HPT") rule requires hospitals to publish standard charges (such as gross charges and payer-specific negotiated rates) for services, while the Transparency in Coverage ("TIC") rule mandates that group health plans and insurers disclose negotiated rates through machine-readable files ("MRFs"). However, despite these regulatory requirements, purchasers had previously found the data to be unusable to improve their health care purchasing practices and reduce their costs – the ultimate intent of the price transparency rules. Prior to this demonstration project, no employer or purchaser-driven organization had completed the complex analytical work necessary to transform the raw data from the MRFs into actionable health care purchasing insights. The project demonstrated that creating actionable information for employers using the transparency data was both technically feasible and valued by employers.

When the Consolidated Appropriations Act ("CAA") of 2021 clarified and refined ERISA fiduciary standards for self-insured employers, the imperative for informed purchasing was reinforced. Accompanying that policy change was the requirement to make health care prices transparent. Informed decision making requires information that had previously been unavailable. Transparency rules for hospitals and health insurers were designed to enable effective purchasing and fiduciary responsibilities.

In the years since these policy changes, there has been progress on public reporting and compliance, but limited uptake or use of the data by self-insured employers. The transparency files released by hospitals and payers, while containing valuable pricing information, remain challenging to use. The files are often published in formats and volumes that few organizations can effectively download, synthesize, and analyze. Large, self-insured purchasers² tasked with managing health plans that provide coverage for thousands to

Transparency is necessary but insufficient; it's how it is used that matters. Some are using this same data to raise prices. Employers and PBGH are using it to achieve affordability for US workers. It's the same data used for a different purpose and – based on CAA – this is arguably its intended purpose.

— Elizabeth Mitchell, President & CEO, PBGH

¹ MRFs are defined under 45CFR160.202 to be a "digital representation of data or information in a file that can be imported or read into a computer system for further processing" such as XML, JSON, and CSV formats.

² Throughout this white paper, "purchaser" will be used to refer collectively to public and private employers as well as non-employer purchasers of health care (e.g., self-funded benefit funds, state health plans, city health plans).

hundreds of thousands of employees and families across diverse geographic markets need granular insights to ensure they are paying fair prices for high-quality services. The price transparency data holds the promise of providing clear prices across providers, but to be maximally reliable and useful for those using it to purchase care, it must be analyzed alongside purchaser-specific claims and demographic information as well as independent, credible measures of health care quality and safety.

PRGH, a 35-year-old nonprofit organization representing large self-insured purchasers, launched the Health Care Data Demonstration Project in August 2024 to assess the utility of TIC and HPT transparency data and provide purchaser-specific insights on the price and quality of care by combining TIC and HPT data with purchaser claims data and quality metrics from established third-party organizations.

This analysis – which reflects the views of PRGH alone, and not those of the data partners who contributed to the Health Care Data Demonstration Project – represents the first systematic attempt to integrate federal transparency files with quality data and purchaser-specific utilization data to inform actual purchasing decisions by self-insured purchasers. The methodology and findings of this project offer important lessons for both health care purchasers and policymakers about the current state of transparency data utility and the (considerable) analytical infrastructure required to realize its potential value.

The PRGH Health Care Data Demonstration Project was supported by funding and valued thought partnership from the Peterson Center on Healthcare (“the Center”). PRGH is grateful to the Center for supporting the project’s design, development, and implementation as well as the dissemination of its results and analysis of the implications for health care policymakers.



2. Summary of Key Findings

The analysis conducted through PBGH's Health Care Data Demonstration project reveals structural problems in the U.S. health care system that purchasers and policymakers cannot ignore. The data confirms wide and often unjustified variation in prices and commercial market dynamics that defy rationality and are not reflective of a competitive market. More importantly, it reveals that it is not always clear where health care dollars that purchasers and patients spend are going; pricing discrepancies invite yet-unanswered questions about if and how intermediaries are profiting in health care transactions, which is a promising and needed area for future investigations and phases of work. What is clear is that purchasers and policymakers alike face a system where spending grows without accountability and affordability of health care is increasingly out of reach.

Simultaneously, the data project reveals the limitations of current federal price transparency efforts. Files required under the TC and HPT rules are frequently so large, inconsistent, or error-ridden that they cannot be used to draw meaningful conclusions. Only by aggregating and validating claims data directly from purchasers has PBGH been able to overcome these barriers. However, this step is only possible for purchasers who have access to their own claims data. By crosswalking claims and price transparency data, it is possible to validate price and identify gaps between published price and paid claims. But employers don't make health care purchasing decisions based solely on price. They are equally—and often more—concerned about the quality and safety of care. Only once quality data is integrated, can purchasers and policymakers finally judge whether high prices are even justified by better outcomes.

A central finding of this analysis is the diverse and increasingly strategic ways in which purchasers are applying price transparency data to inform health care procurement and network design. For instance, purchasers expressed

a clear readiness to apply price and quality data to health care purchasing practices to lower costs and increase affordability and quality, like using rates and relative value in medical carrier requests for proposal ("RFPs"), applying quality and physician safety ratings to validate direct contracts and designate Centers of Excellence, and leveraging data project insights for steering and network design. Looking ahead, purchasers plan to expand these applications to ensure payment integrity, health care claims audits and repricing, and identify overpayments by comparing prices reported in transparency files with their paid claims. The individualized employer reports generated through this project equipped each participating purchaser with actionable insights to identify high-performing provider partners, which will ultimately lead to higher quality care and lower costs.

Key findings on Transparency-in-Coverage, Hospital Price Transparency and Purchasers' Claims Data:

- **TC and HPT data usability varies dramatically.** Usability of the price transparency files ranged from excellent in some regional markets (Seattle) to largely unusable in others (Oregon, California). Hospital price transparency data posed greater analytical challenges and was generally inferior to payer submissions. However, the combination of HPT and TC datasets with purchaser-specific claims data improved data completeness where gaps exist, and created a usable data set.
- **Claims data access barriers persist.** Despite clear legal rights for purchaser data access under Section 201 of the CMA, 2021, service providers, such as third-party administrators ("TPAs") and health insurance carriers, frequently challenged purchasers' access to their own claims data, citing proprietary concerns or provider contract restrictions.

* Throughout this paper, "service providers" will be used to refer to one to both TPA (for self-insured purchasers) and health insurance carriers (in a context where a purchaser who is primarily self-insured may also offer some fully insured plans in certain regional markets, as a portion of their portfolio).

clinical outcomes. Notably, provider reputation or brand was not a reliable indicator of quality, underscoring the disconnect between the market and actual performance.

- **Analytical infrastructure is essential.** The conversion of publicly available price transparency files into reliable and actionable information necessitates advanced analytic capacity and significant resource investment that most purchasers currently lack. The files are frequently voluminous, inconsistent, and error-ridden, rendering them impractical for purchasers to use on their own. To ensure validity and utility, price transparency data must be integrated with purchaser-specific claims data and subjected to actuarial methods that can confirm the accuracy of results. Absent such infrastructure, most purchasers lack the technical and financial capacity to independently operationalize these datasets.
- **Meaningful cost comparisons are otherwise unavailable.** Participating purchasers reported having no other source of independent, usable price data from service providers or consultants/advisors. The prevailing method of relying on “discount analyses” of proprietary carrier data is flawed since actual prices are kept hidden and thus cannot be verified.

Key Market Findings:

- **Price variation defies economic logic.** Pricing varied within and between regional markets, and among and across different payers in the same facilities. For example, median reported negotiated facility rates for a cesarean section without complication or other concurrent procedures ranged from \$11,547 (Chicago) to \$27,199 (Northern California). There were also variations of price within the same facility. At one hospital, the negotiated rate for the same medication varied by 49% between two plans. This variation exemplifies why purchasers need visibility into real prices to ensure they are meeting fiduciary obligations and not overpaying for health care products and services.
- **Price and quality are not correlated.** Analysis revealed that higher-priced providers frequently performed worse on standardized quality measures, while lower-priced providers often demonstrated superior safety and

- **Site-of-service savings are market-specific.** Potential cost savings from shifting care from hospital outpatient settings to ambulatory surgical centers (ASC) varied dramatically across regional markets. Pricing differences ranged from minimal in some regions to as much as \$2,000 per knee replacement procedure in others. These wide variations underscore the importance of localized and provider-specific data and regionally tailored purchasing strategies, rather than a one-size-fits-all approach.

- **Insurer or service provider market share does not always predict competitive pricing.** Some service providers with limited market penetration achieved superior negotiated rates compared to dominant market players. This finding raises questions beyond the scope of this initial analysis about the degree to which empirical data on negotiated rates suggests that service providers’ business interests are aligned (or not) with the interests of purchasers and patients. Future analyses will be able to shed more light on this issue.

- **Price transparency enables meaningful commercial benchmarking and comparisons.** Transparency data makes it possible for purchasers to systematically compare commercial prices across services and markets. This allows purchasers to evaluate whether their service providers have negotiated competitive rates, establish reference points for what constitutes a fair price, and identify instances of overpayment. Price comparison also provides a foundation for accountability, enabling purchasers to press service providers for more reasonable rates, or to circumvent intermediaries by engaging in direct contracting with high-value providers.* Overall, access to actual price data equips purchasers with the information needed to assess price competitiveness and advance value-based purchasing strategies.

* Purchasers can – and in fact have – demonstrated that direct contracting with high-quality providers can result in significant cost savings. Juniper purchasers like Lowe’s, Wal-Mart, Mission and JetBlue always show real notable savings when they contract directly with providers. For example, Juniper purchasers like Lowe’s, Wal-Mart, Mission and JetBlue consistently work through the Employer Center of Excellence Network (ECCN), and the participating employers saved \$1.6 million (4% of medical costs) across the program year for employees having lower costs, better outcomes, and better experiences.

3. Methods and Data Sources

PRGH worked directly with members and leveraged its three-and-a-half decades of experience working with large, self-insured purchasers to design analytical approaches focused on high-priority decision-making needs identified by participating purchasers. Our data partners who supported the project also leveraged their deep actuarial and provider contracting subject matter expertise.

PRGH engaged five large, self-insured purchasers across 10 U.S. regional markets, who provided their de-identified health care claims data to enable analysis of their specific utilization patterns and spending.⁴ The participating organizations collectively employ more than 650,000 people and represent diverse industry sectors and geographic footprints (See [Appendix 1](#) for a detailed list of the 10 regional markets and the hospitals, provider groups, and payers whose data was assessed).

The analytical framework incorporated four primary data sources:

- **Price Transparency Data.** The foundational dataset with HPT and TIC files was cleaned and licensed from Turquoise Health, and was then enriched and enhanced by Milliman to overcome data quality challenges inherent in current transparency file submissions. Milliman's approach includes validation algorithms, standardization procedures, and usability scoring mechanisms that are essential for reliable analysis.
- **Provider Quality Data.** Provider-level quality metrics were obtained from Embold Health, which aggregate clinical outcome and provider performance measures.
- **Hospital Safety Data.** Spring 2025 Hospital Safety Grades were sourced from the Leapfrog Group, which maintains comprehensive safety ratings based on infection rates, safety practices, and harm prevention measures.
- **Claims and Demographic Data.** Participating purchaser provided 36 months of historical claims data to enable analysis of their specific utilization and payments, which allowed for purchaser-specific insights rather than generalized market assessments. Claims data was used primarily to understand patterns of health care utilization for each purchaser's population, including location and frequency of different services. This ensured purchaser-specific recommendations were appropriate and tailored to the patient population and service area. In addition, claims data was used to ensure we were referencing the correct transparency files, since each service provider often has multiple plans, which can have varying negotiated rates.

⁴ For an explanation of the enhancements Milliman applied to the data to overcome limitations with it, see PRGH's first whitepaper, [Data as a Data Ecosystem](#), beginning on p. 10.



Data Usability Assessment Methodology

A critical component of the analysis involved assessing the completeness and usability of the HPT and TIC MRIs for purchasing decisions. The analysis identified multiple gaps in reporting and significant variability across regional markets and plans.

To quantify the usability of the posted HPT and TIC data, we deployed a “Percent of Expected” metric that focuses on the analytical utility rather than regulatory compliance, as MRIs can technically satisfy legal requirements under the HIPAA rules while remaining unusable for analytical purposes. The metric assesses the data against the Global Relative Value Units (“GRVUs”), associated with transparency data where negotiated rates are available (or can be derived) and deemed reasonable, expressed as a percentage of the total RVUs we would expect for the given provider type and line of business (“LOB”) if all negotiated rates were available.**

For example, a Percent of Expected value of 90% indicates that the posted data reflects 90% of the total volume of services one would expect to be present, which represents a comprehensive data point. Percent of Expected values between 60 – 79% are considered generally usable, 25 – 59% are considered partially usable, and 0 – 24% are considered unusable. It is important to note that less than 25% implies the need for code level data investigation. These categories provide purchasers with clear guidance about the reliability of analytical conclusions that can be drawn from available transparency data in specific regional markets.

* GRVUs are a set of Relative Value Units (RVUs) that cover the entire range of healthcare services. GRVUs can be thought of as an all-payer version of Medicare reimbursement rates as it encompasses common limitations of contract comparisons that are not applicable to Medicare. GRVUs are not subject to the same regulatory requirements as Medicare reimbursement rates and are not captured (documented by an ICD-10/ICD-9/ICD-10 procedure code) in the same way as Medicare. GRVUs are not subject to the same regulatory requirements as Medicare reimbursement rates and are not captured (documented by an ICD-10/ICD-9/ICD-10 procedure code) in the same way as Medicare. GRVUs are not subject to the same regulatory requirements as Medicare reimbursement rates and are not captured (documented by an ICD-10/ICD-9/ICD-10 procedure code) in the same way as Medicare.

** A more detailed explanation of the “Percent of Expected” metric – and other aspects of the data usability methodology – can be found in Appendix 2.

4. Results

1. Data Usability Varies Dramatically Across Regional Markets and Between HPT and TIC MRFs, With Implications for Purchasers

PGHF's Health Care Data Demonstration Project showed that hospital and payer compliance has increased in form, but not in function. Although submissions technically meet regulatory requirements, the HPT and TIC files are plagued by formatting inconsistencies, omissions and usability barriers that renders much of the data unusable for purchasers, policymakers, researchers, and consumers. Regardless of intent, these shortcomings obscure the value of the data and prevent purchasers and consumers from leveraging it to lower health care costs.

The data project identified several recurring issues; lack of standardized file structures, missing or inaccurate data, inapplicable entries, and the absence of indexing information needed to make the files searchable and comparable. These findings confirm and extend the work of other policy researchers who have conducted meta-analyses and highlighted and documented a wide spectrum of technical flaws in the transparency submissions. These problems create a troubling – but addressable – gap between current regulatory compliance standards and the federal government's goal of producing data that is actionable for purchasers and consumers and lowering health care costs through a more transparent and competitive market.

For example, one service provider's submission included all negotiated rates across all contracts for each procedure, but failed to link those rates to specific plans or networks. While technically compliant, the file was functionally useless. In some cases, the inconsistencies were so severe that the entire MRF had to be excluded from analysis. For example, over 60% of the MRFs in Oregon were generally not reliable.

The implications of MRF data usability challenges are particularly significant for self-insured purchasers who bear fiduciary responsibilities for managing health care dollars on behalf of their workforces. These shortcomings greatly undermine their ability to fulfill their fiduciary duties on two fronts:

1. **Regulatory compliance.** Federal rules state that "it is ultimately the responsibility of the plan or issuer to provide the information required by the final rules." Self-insured purchasers must therefore implement processes to assess the usability of submitted data and hold their service providers accountable for addressing any identified data flaws or deficiencies in the files.

2. **Fiduciary prudence.** Purchasers must make fiscally prudent decisions about employees' health care benefits. When the underlying price transparency data is unreliable or unusable, purchasers face significant legal risks as fiduciaries.

Nationally, the project's analysis (Figure 1) shows wide variation in the usability of the TIC data. In the Seattle/Puget Sound region, approximately two-thirds of payer data achieved the highest usability ratings, with especially usable hospital inpatient data (Figure 2). Across most markets, inpatient data was more reliable than outpatient data. However, data posted for Oregon and California exhibited substantially lower usability, with large portions of the submissions rated unusable. Notably, Kaiser's submissions were universally unusable in all regional markets that were analyzed, and therefore were excluded from all analyses (detailed examples showing the usability of TIC data by regional market is in [Appendix 3](#)).



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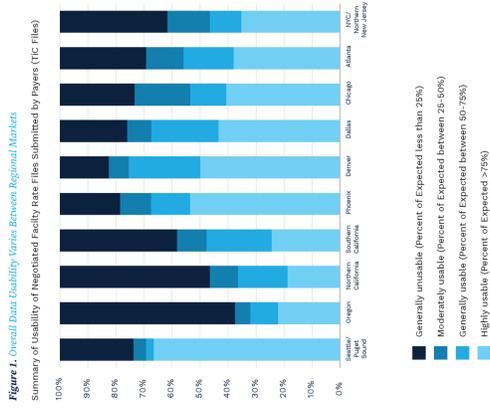
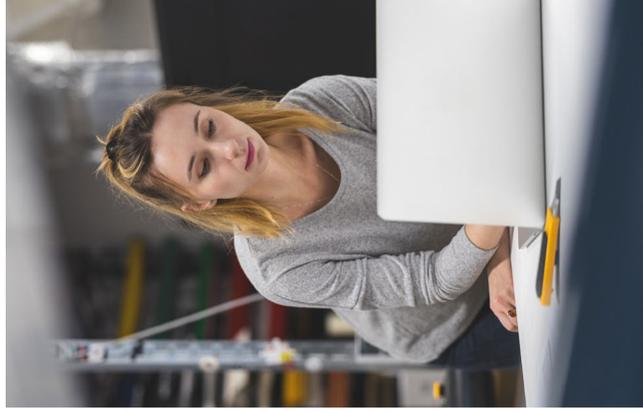


Figure 2. Data Usability in TIC Files is Inconsistent Even Within the Same Service Provider Data usability ("Percent of Expected") ratings for TIC files in Seattle/Puget Sound regional market.

Payer Transparency Data	Leapfrog Hospital Safety Score		Aetna Choice POS II		Premier Blue Cross Heritage		Regence BCBS Regional Preferred		Cigna Cigna GAP		UnitedHealthcare UHC Choice Plus	
	Lead/rog Hospital	Safety Score	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Cascade Valley Hospital	D		●	●	●	●	●	●	●	●	●	●
Evergreenhealth Medical Center	A		●	●	●	●	●	●	●	●	●	●
Evergreenhealth Monroe	N/A		●	●	●	●	●	●	●	●	●	●
Fred Hutchinson Cancer Center	N/A		●	●	●	●	●	●	●	●	●	●
Harborview Medical Center	C		●	●	●	●	●	●	●	●	●	●
Kaiser Permanente Central Hospital	N/A		●	●	●	●	●	●	●	●	●	●
Multicare Auburn Medical Center	B		●	●	●	●	●	●	●	●	●	●
Multicare Covington Medical Center	A		●	●	●	●	●	●	●	●	●	●
Multicare Good Samaritan Hospital	C		●	●	●	●	●	●	●	●	●	●
Multicare Mary Bridge Children's Hospital	N/A		●	●	●	●	●	●	●	●	●	●
Multicare Tacoma General Hospital	B		●	●	●	●	●	●	●	●	●	●
Overlake Hospital Medical Center	B		●	●	●	●	●	●	●	●	●	●
Overlake Hospital Medical Center Everett	C		●	●	●	●	●	●	●	●	●	●
Providence Regional Medical Center Everett	C		●	●	●	●	●	●	●	●	●	●
Seattle Children's Hospital	N/A		●	●	●	●	●	●	●	●	●	●
St. Anne Hospital	N/A		●	●	●	●	●	●	●	●	●	●
St. Anthony Hospital	A		●	●	●	●	●	●	●	●	●	●
St. Clare Hospital	A		●	●	●	●	●	●	●	●	●	●
St. Elizabeth Hospital	N/A		●	●	●	●	●	●	●	●	●	●
St. Francis Hospital	B		●	●	●	●	●	●	●	●	●	●
St. Joseph Medical Center	A		●	●	●	●	●	●	●	●	●	●
Swedish Cherry Hill Campus	B		●	●	●	●	●	●	●	●	●	●
Swedish Edmonds Hospital	C		●	●	●	●	●	●	●	●	●	●
Swedish Edmonds Hospital	B		●	●	●	●	●	●	●	●	●	●
Swedish Isaquah	B		●	●	●	●	●	●	●	●	●	●
Swedish Medical Center	A		●	●	●	●	●	●	●	●	●	●
University of Washington Medical Center - Montlake	C		●	●	●	●	●	●	●	●	●	●
UW Medicine/Northwest Hospital	N/A		●	●	●	●	●	●	●	●	●	●
Valley Medical Center	D		●	●	●	●	●	●	●	●	●	●
Virginia Mason Medical Center	A		●	●	●	●	●	●	●	●	●	●

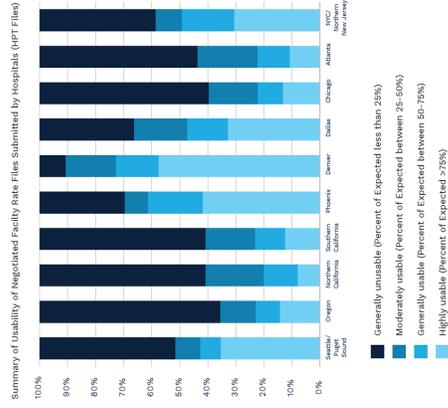
Percent of Expected: ● 0-25% Generally unusable, recommend additional investigation ● 26-50% Moderately usable, recommend additional investigation ○ 51-75% Generally usable, consider additional investigation ● 76-100% Highly usable



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In Figure 3, we offer a national overview of the usability of the HPT data, and in Figure 4, we offer specific examples of HPT data from the Seattle/Puget Sound regional market (detailed examples showing the usability of HPT data by regional market are in Appendix 3).

Figure 3. HPT Files Tend to be Less Usable Than TIC Files



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Figure 4. Specific Hospitals and Health Systems Did Not Consistently Submit Usable HPT Files

Data usability ("Percent of Expected") ratings for HPT files in Seattle/Puget Sound regional market.

Hospital	Leapfrog Hospital Safety Score	Aetna Choice POS II		Premier Blue Cross Heritage		Regence BCBS Regence Preferred		Cigna GAP		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Cascade Valley Hospital	D	●	○	●	○	●	○	●	○	●	○
Evergreenhealth Medical Center	A	●	○	●	○	●	○	●	○	●	○
Evergreenhealth Monroe	N/A	●	○	●	○	●	○	●	○	●	○
Fred Hutchinson Cancer Center	N/A	●	○	●	○	●	○	●	○	●	○
Nationview Medical Center	C	●	○	●	○	●	○	●	○	●	○
Kaiser Permanente Central Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Multicare Auburn Medical Center	B	●	○	●	○	●	○	●	○	●	○
Multicare Covington Medical Center	A	●	○	●	○	●	○	●	○	●	○
Multicare Good Samaritan Hospital	C	●	○	●	○	●	○	●	○	●	○
Multicare Mary Bridge Children's Hospital	N/A	○	○	○	○	○	○	○	○	○	○
Multicare Tacoma General Hospital	N/A	○	○	○	○	○	○	○	○	○	○
Overlake Hospital Medical Center	B	●	○	●	○	●	○	●	○	●	○
Providence Regional Medical Center Everett	C	●	○	●	○	●	○	●	○	●	○
Seattle Children's Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Snoqualmie Valley Hospital	N/A	○	○	○	○	○	○	○	○	○	○
St. Anne Hospital	A	●	○	●	○	●	○	●	○	●	○
St. Anthony Hospital	A	●	○	●	○	●	○	●	○	●	○
St. Clare Hospital	A	●	○	●	○	●	○	●	○	●	○
St. Elizabeth Hospital	N/A	○	○	○	○	○	○	○	○	○	○
St. Francis Hospital	B	●	○	●	○	●	○	●	○	●	○
St. Joseph Medical Center	A	●	○	●	○	●	○	●	○	●	○
Swedish Cherry Hill Campus	C	●	○	●	○	●	○	●	○	●	○
Swedish Edmonds Hospital	B	●	○	●	○	●	○	●	○	●	○
Swedish Issaquah	B	●	○	●	○	●	○	●	○	●	○
Swedish Medical Center	A	●	○	●	○	●	○	●	○	●	○
University of Washington Medical Center — Montlake	C	●	○	●	○	●	○	●	○	●	○
UW Medicine/Northwest Hospital	N/A	○	○	○	○	○	○	○	○	○	○
Valley Medical Center	D	○	○	○	○	○	○	○	○	○	○
Virginia Mason Medical Center	A	●	○	●	○	●	○	●	○	●	○

Percent of Expected: ● 0-25% Generally unusable, recommend additional investigation; ○ 26-50% Moderately usable, recommend additional investigation; ● 51-75% Generally usable, consider additional investigation; ● 76-100% Highly usable

Hospital-submitted data generally presented greater analytical challenges than payer-submitted data. In Seattle, slightly more than one-third of hospital data sets were assessed with the highest usability ratings, while nearly half were rated as generally unreliable. Denver was a notable exception, where HPT data in that market actually was more usable than payer TIC data – this may be attributed to the Colorado Department of Health Care Policy & Financing's actions to use and report on HPT data. This suggests that state oversight and purchaser attention can positively influence the usability of the data files.

Overall, there are several recurring issues that limit transparency file utility:

- **Custom billing codes.** Hospitals and Payers frequently reported custom billing codes that lack industry-standard definitions, making external interpretation impractical without providing a crosswalk to valid code sets.
- **"Percentage of Charge" submissions.** Submissions often provided only percentage-of-charge rates without accompanying billed charge information clarifying which services the percentages applied to.
- **Schema inconsistencies.** Hospitals and payers interpreted the federal schema in divergent ways, which prevented automated processing and comparative analysis across institutions.
- **Duplicate or conflicting rates.** Some files included duplicate or contradictory rates for the same service/provider/network combinations without explanatory context.

2. Price Variation Defies Economic Logic

When usable pricing data was successfully extracted and analyzed, it revealed patterns that challenge fundamental economic assumptions about how markets operate. Unlike Medicare reimbursement rates, which incorporate systematic adjustments for regional cost differences through wage indexes and other factors, commercial negotiated rates vary arbitrarily and drastically between and within regional markets.

Our analysis documented cases where the commercial rate for identical medical procedures varied by more than 100% between regional markets. For example, median negotiated rates for a Cesarean section without complications ranged from \$11,547 in Chicago to \$27,199 in Northern California. This level of variation far exceeds plausible differences in local labor costs, facility expenses, or other measurable economic factors (see Figure 5 for additional variability in negotiated rates across service categories).

Another critical finding is that purchasers now have the ability to benchmark and compare actual prices in geographic regions for various services. Prior to the availability of the price transparency files, negotiated rates were considered proprietary and not shared when evaluating service providers and networks. Service providers would present negotiated rates to purchasers not as actual dollar amounts, but instead as average regional discounts off providers' billed charges (e.g., a "discount analysis"). Figure 5 shows the range of actual median market prices by service. Despite relying on median prices for just 10 regional markets, the data from Figure 5 allows purchasers to understand the range of prices for certain services, which gives purchasers increased negotiating capabilities. We ultimately believe that when commercial price transparency is used effectively by self-insured purchasers, it will lead to price competition and rationalization of commercial prices and ultimately lower costs.

* Prewling price ranges, informed by independent sources of market data from the price transparency files, are also provided what will enable purchasers to be effective in-house. This information will allow purchasers to demonstrate they have satisfied the standard conditions under ERISA's 404(a)(0)(B) to make health care purchasing decisions using the knowledge available to them "under the prevailing circumstances."

Figure 5. Range of Median Negotiated Rates Across 10 Regional Markets for Subsets of Billing Codes

Code	Description	Range of Median Negotiated Rates (by Site of Care)
Pregnancy, Childbirth & the Puerperium Diagnosis Related Group Codes		
786	Cesarean section w/o sterilization w Cc	Facility \$19,420 - \$45,984
787	Cesarean section w/o sterilization w Mcc	\$13,513 - \$45,652
788	Cesarean section w/o sterilization w/o Cc/Mcc	\$11,547 - \$27,099
806	Vaginal delivery w/o sterilization/ D&C w Cc	\$9,235 - \$26,460
807	Vaginal delivery w/o sterilization/ D&C w/o Cc/Mcc	\$8,134 - \$18,369
Gastroenterology Endoscopic Codes		
43239	Egd biopsy single/multiple	Outpatient \$2,309 - \$4,209
45378	Diagnostic colonoscopy	Outpatient \$2,309 - \$4,241
45380	Colonoscopy and biopsy	Outpatient \$2,607 - \$4,696
45385	Colonoscopy w/lesion removal	Outpatient \$2,639 - \$4,686
Orthopedic Joint Replacement Codes		
27130	Total hip arthroplasty	Outpatient \$16,000 - \$50,321
27447	Total knee arthroplasty	Outpatient \$16,000 - \$50,321
Emergency Department Visit Evaluation and Management Codes		
99283	Low level of medical decision making	Outpatient \$807 - \$21,098
99284	Moderate level of medical decision making	Outpatient \$1,311 - \$3,242
99285	High level of medical decision making	Outpatient \$1,536 - \$4,674
Ambulatory Surgical Center		
Continued on next page		

Figure 5. (continued)

Code	Description	Range of Median Negotiated Rates (by Site of Care)	
Outpatient Office Visit Evaluation and Management Codes			
	Outpatient	Non-Facility	
99212	Established patient visit, straight forward medical decision making, 10-19 minutes	\$152 - \$431	\$67 - \$79
99213	Established patient visit, low level medical decision making, 20-29 minutes	\$176 - \$281	\$108 - \$127
99214	Established patient visit, moderate medical decision making, 30-39 minutes	\$189 - \$301	\$154 - \$185
99215	Established patient visit, complex medical decision making, 40-59 minutes	\$216* - \$548	\$218 - \$270
Drugs and Biological Codes			
	Outpatient		
J2350	Injection, ocrelizumab	\$59 - \$122	
J3380	Injection, vedolizumab	\$22 - \$48	
J9271	Injection pembrolizumab	\$58 - \$104	

* Median price of Denver regional market was excluded from this range due to reporting anomalies from number of facilities reporting rates for this code. For example, one facility reported rates for this code with a "Report count" of 0. Frequency of anomalies vary between different services, so consult rates office.

Significant pricing variation emerged within individual facilities depending on the negotiating insurer. One particularly striking example involved ocrelizumab (J2350), a specialty medication for multiple sclerosis treatment, where a single hospital had negotiated rates across health plans ranging from \$75 to \$112 per milligram – a 49% price disparity that translates to a difference of approximately \$22,000 per typical 600mg treatment course.

Regional pricing patterns also failed to follow consistent economic logic across service categories. For example, Northern California showed the highest rates for maternity services (Figure 6), Oregon emerged as the price outlier for orthopedic procedures (Figure 7), and Northern California and Denver showed the highest median emergency department visit rates (Figure 8). This inconsistency in which regional market consistently had higher rates suggests that commercial pricing is influenced by dynamics other than or in addition to underlying cost structures.

Figure 6. Payer Submitted TRC Files Show Higher Median Rates in Northern California for Vaginal Delivery without Complication (DRG 807)

Negotiated Facility Rates (25th-75th percentile) for Vaginal Delivery without Complication (DRG 807) by Regional Market

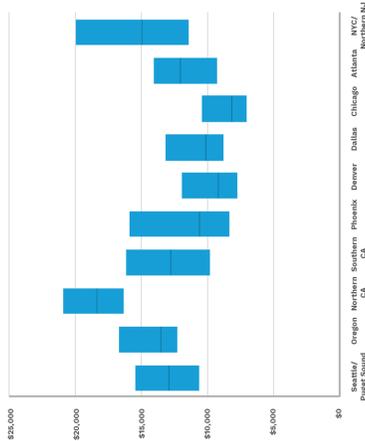


Figure 7. Payer Submitted TIC Files Show Higher Median Rates in Oregon for Total Hip Replacements (27130)

Outpatient Negotiated Facility Rates (25th-75th percentile) for Total Hip Arthroplasty (27130) by Regional Market

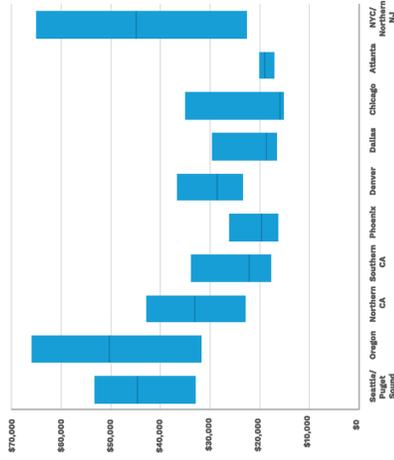
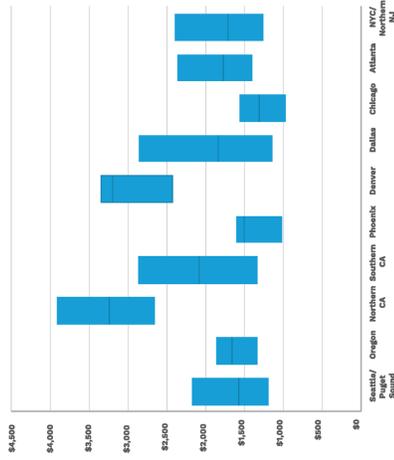


Figure 8. Payer Submitted TIC Files Show Higher Median Rates in Northern California and Denver for Emergency Room Visits (92284)

Negotiated Facility Rates (25th-75th percentile) for Emergency Room Visit (92284) by Regional Market



3. Price Does Not Correlate with Quality

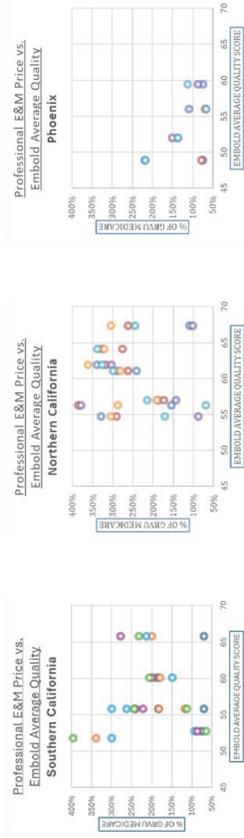
Integration of health care quality metrics with pricing data confirmed longstanding analysis of health care market dysfunction: higher priced providers do not reliably deliver higher-quality care, and in some cases the lowest-cost provider had higher quality scores.⁷ Across multiple regions and service categories, the analysis found little to no correlation between negotiated rates and standardized quality measures.

Higher-priced providers did not consistently outperform their lower-priced peers on standardized quality metrics. As demonstrated in Figure 9, lower-priced providers sometimes achieved superior performance on Embold Health's clinical outcome measures. Likewise, some of the most expensive hospitals received a "Poor" safety rating from the Leapfrog Group (see Figure 14). These findings suggest that commercial pricing reflects factors such as provider market power,⁸ brand loyalty, and market positioning, rather than clinical excellence or patient outcomes.

The absence of a price-quality correlation carries significant implications for purchasing strategies. Traditional approaches assuming higher prices indicate superior care are not supported by empirical evidence. Instead, the data indicates that strategic network design based on value – explicitly integrating both price and quality – can improve patient outcomes while reducing spending.

Importantly, the data project was able to identify providers and facilities that combine high-quality performance with lower prices. However, further analysis revealed that existing service provider networks, including those labeled as "high-value networks," showed little alignment with either price or quality data. In contrast, directly negotiated and contracted purchaser arrangements with hospitals and delivery systems were associated with lower negotiated rates and higher value. These results raise critical questions about health plan network design and underscore the potential for purchaser-led contracting strategies to drive better outcomes and value.

Figure 9. Relationship Between Price and Quality⁷



⁷ Some of the data at the lower end are sufficiently low as to likely to be irrational and/or misreported. Additionally, the differences in color of dots merely indicate different providers. Figure 9 conveys that there is not a correlation between price and Embold quality scores.

4. Site-of-Service Analysis Reveals Substantial Savings Opportunities

The price transparency data enabled detailed examination of price variation across different sites of care, highlighting significant opportunities for purchasers to redirect beneficiaries to lower-cost providers or settings when clinically appropriate. These opportunities, however, were highly market specific, underscoring the need for regional rather than national steering strategies.

For example, analysis of total knee replacement procedures revealed dramatic differences across the regional markets. In St. Louis, the median negotiated facility rate at an ambulatory surgical center (ASC) was nearly \$2,000 lower than the median rate at a hospital. This finding suggests a significant potential for appropriate candidates. However, in Chicago, both ASC and hospital outpatient department negotiated facility rates both clustered around \$16,000. This may indicate either a lack of site-of-service differentiation in TIC files or genuinely limited financial incentive for steering in that regional market (Figures 10 and 11).



Figure 10. Negotiated Facility Rates for The Same Procedure Can Vary Significantly by Site of Service

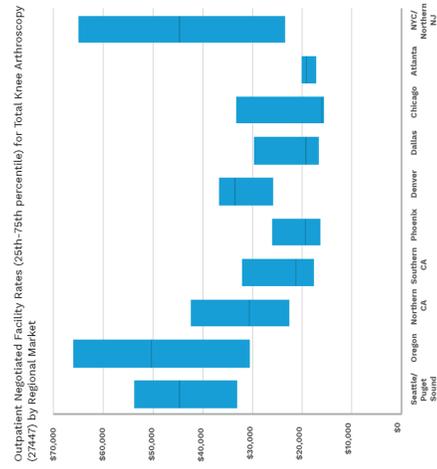
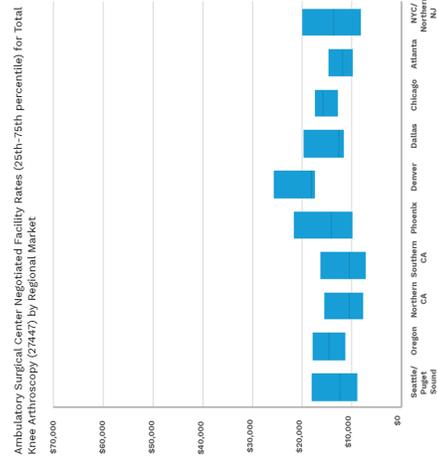


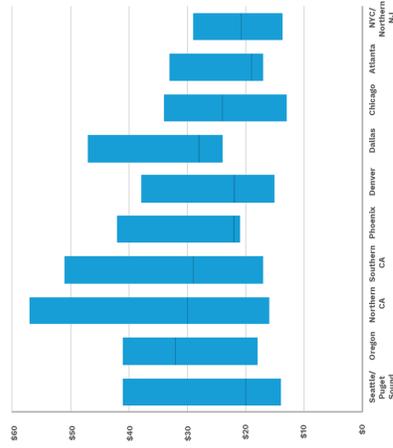
Figure 11. Site of Service Matters for Price of Care - Ambulatory Surgical Center Negotiated Facility Rates Lower Than for Outpatient Facility Rates



Wide variation was observed for high-volume, lower-cost services such as laboratory testing. In states like Oregon and California, hospital outpatient laboratory prices were approximately double those at non-facility settings for identical tests (See Figures 12 and 13).

Figure 12. Lab Test Rates Differ by Site-of-Service - Outpatient Lab Test Rates Significantly Higher Than Non-Facility Lab Test Rates

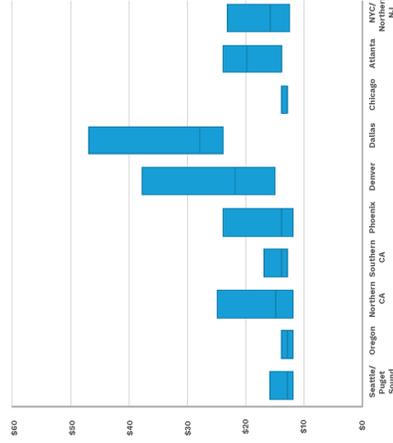
Non-Facility Lab Negotiated Rates (25th-75th percentile) for Comprehensive Metabolic Panel (80053) by Regional Market



Redirecting even half of laboratory utilization from hospital outpatient departments to independent labs could generate savings exceeding \$1 million annually for a large purchaser, based on conservative estimation.* Savings would also accrue to employees both in reduced cost sharing as well as potentially lower premiums.

Figure 13. Non-Facility Lab Test Rates Significantly Lower Than Outpatient Lab Test Rates

Non-Facility Lab Negotiated Rates (25th-75th percentile) for Comprehensive Metabolic Panel (80053) by Regional Market



* Assuming a plan sponsor with an estimated total health care spend of around \$500 million in regional markets where this opportunity is present, and current spend on facility Lab services is around 1% of total spend.

- **Quality misalignment.** Price differences bore little relationship to quality performance. For example, EvergreenHealth Medical Center, which received the highest Leapfrog Safety Grade (A), had the lowest negotiated rates across plans, while other hospitals with lower safety scores commanded higher prices.
- **Consistency across markets.** Similar pricing disparities were observed across hospital systems in each of the 10 regional markets.

Figure 14. Carrier/Service Provider Pricing Variance Using % of GRU Medicare Rates*

Inpatient Negotiated Facility Rates						
Provider Name	Leapfrog Safety Grade (Using 2025)	Aetna Choice POS II	Premiera Blue Cross Heritage	Regence BCBS Reference Preferred	Cigna OMP	United Healthcare UHC Choice Plus
EvergreenHealth Medical Center	A	225%	239%	238%	195%	235%
Providence Regional Medical Center Everett	C	Poor data usability	350%	387%	467%	367%
Swedish Medical Center	B	Poor data usability	342%	507%	425%	424%

5. Competing Plans Pay Substantially Different Rates — Even In the Same Markets

Self-insured purchasers most often rely on their TPA or service providers to negotiate on their behalf with providers in their given markets. Our analysis of TIC, HPT, and purchaser claims data often found wide variations in the health care provider prices across major health plans in the same markets.⁹

For example, in the Seattle/Puget Sound regional market, we analyzed the TIC data for five health plans offered by leading carrier/service providers — Aetna, Cigna, Premiera Blue Cross, Regence BCBS, and UnitedHealthcare — and compared negotiated inpatient facility rates at EvergreenHealth Medical Center, Swedish Medical Center, and Providence Regional Medical Center Everett (See Figure 14).

Although data usability issues prevented full comparisons in some cases, sufficient data usability allowed for meaningful analysis in others. Key findings included:

- **Service Provider variation.** Negotiated rates varied widely by service provider, even within the same hospital. Regence BCBS generally had the highest rates, while Premiera secured lower negotiated rates despite having similar market share. Cigna negotiated the lowest rates at EvergreenHealth, despite having a lower local market share than other health plans.¹⁰
- **Hospital variation.** Regence BCBS negotiated inpatient rates for Swedish Medical Center were nearly 50% higher than Premiera Blue Cross' rates.

* Negotiators refer to the percent difference between the prices charged to insurers and prices charged to self-insured Medicare beneficiaries, using statements' Global Relative Value Units (GRU) as a calculation methodology, which is outlined in more detail in the companion report, "Statement of GRU Data Discrepancies." Market averages for GRU to calculate negotiated Medicare payments that represent common estimates of contract comparators that are subject to the analysis. The Leapfrog Hospital Safety Grade Program grades hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. For more information visit www.leapfrogdata.com.



These findings raise fundamental questions about the value that self-insured plan sponsors derive from TPAs, service providers, or carriers who negotiate on their behalf. Purchasers rely on these entities and the industry consultants who help select them, to secure competitive rates. Yet the evidence further shows that rates differ substantially by carrier/TPA/service provider, often without correlation to quality. Participating purchasers indicated that no similar source to compare TPA negotiated rates was available.

The ability to make these types of apples-to-apples pricing comparisons across service providers is precisely what federal transparency regulations were intended to achieve. Both the Trump Administration's price transparency rules and Congress' prohibition of claims data access barriers in the CAA sought to provide purchasers with the tools to evaluate service provider performance, costs, and fulfill their fiduciary duty.

We encouraged our employees to enroll in a high-deductible health plan. And, what we've realized [with this data] is that, it's probably not a great plan. It was the thing to do, a decade ago, but, it is time for us to modernize our healthcare...
—Jumbo Employer

5. Purchaser Applications and Strategic Implications

Fiduciary Compliance, Risk Management, Network Design, and Value-Based Strategies

The availability of price transparency data creates both opportunities and obligations under ERISA for self-insured purchasers and, in some cases, their service providers when they act as functional fiduciaries.¹¹ PGH launched this project to address purchasers' unmet analytic needs, bringing together all relevant data sets to test the practical utility of newly available transparency files. For the first time, participating purchasers were able to evaluate their spending, assess their service provider's compliance with transparency reporting obligations, and reduce risk by demonstrating prudent oversight of plan performance.

Purchasers can now integrate price and quality data into their strategies across four key areas:

1. Compliance monitoring
2. Value-based purchasing
3. Direct contracting
4. Vendor procurement

Findings challenged conventional assumptions about the relationship between carrier/service provider market share and the rates they have negotiated. In several markets, for instance, carriers and service providers with limited market penetration achieved superior negotiated rates compared to dominant market players, contradicting the rationale for ongoing consolidation. This evidence suggests that, as with health systems, carrier and service provider consolidation and scale do not consistently yield better rates for purchasers, with significant implications for policymakers evaluating statements and claims of health insurers in merger and acquisition proposals.¹²

Integration of price, quality, claims, and demographic data enables purchasers to design sophisticated network strategies that were previously impossible. PGH helped purchasers in the project identify high-value providers, including those that may be more expensive but with consistently better outcomes, and are now exploring strategies to steer plan members towards these providers. The analysis also revealed that "high-performance networks" offered by service providers did not consistently align with objective quality or value measures, underscoring the potential for purchasers to construct their own high-value networks and end arrangements with high-cost, low-quality providers.¹³

¹¹ For further analysis of the problematic nature of consolidation in health care markets (including in health insurance markets), see FIGURE 2024.001 (Accession to COL, HHS, and FTC) and our 2023 [Comments on DOJ's Anticompetitive Regulations Task Force](#).

¹² Eliminating low-value health care coverage supports for trust matter from a group health plan may be a duty for plan fiduciaries comparable to the "continuing duty to monitor [plan options] and remove imprudent ones under trust law," *Sutcliffe*, in the 2015 Supreme Court case *Tibbs v. Edison International*. However, this is an unexplored and unresolved issue in the health benefits context.

Case Study: Qualcomm Inc. Incorporated Use of Transparency Data

Qualcomm Inc., a San Diego-based global communications technology company with more than 15,000 U.S. employees (a majority of whom live near company headquarters) applied the PBGH data project analysis across four strategic domains:

1. **Compliance Monitoring.** While federal rules clearly state that self-insured purchasers are not necessarily responsible for generating transparency files, they are ultimately responsible for the accurate and timely publication of MRPs associated with the health plan coverage they offer to employees.¹⁴ Working alongside PBGH staff, Qualcomm Inc. determined that its TPA-submitted files were incomplete or unusable. With PBGH's analysis, Qualcomm Inc. approached its TPA with targeted questions about file completeness and usability, enabling proactive compliance management rather than reactive risk assessment.
2. **Value-Based Purchasing.** Qualcomm Inc. used PBGH's price comparison analysis to identify provider price variation for medications and high-volume services, and to view those differences in the context of safety and quality performance. This positioned the company to negotiate more strategically and to steer patients toward higher-value providers.
3. **Direct Contracting Validation.** With most employees located in San Diego, Qualcomm Inc. had already pursued direct contracting with a local health system. However, it lacked independent data and knowledge to determine whether its rates were favorable. PBGH's data analysis enabled Qualcomm Inc. to validate its contracting strategy against prevailing market rates.

... it actually is helping us meet our responsibilities as the plan sponsor and also it's enabling us to question our carriers, and hold them accountable for data accuracy and addressing any gaps.

— Sabina Mahoney, Qualcomm

4. **Procurement Enhancement.** Self-insured purchasers often rely on consultants to support carrier or TPA request-for-proposal ("RFP") evaluations. These firms use a range of methods to determine the prices that various carriers or TPAs pay for health care services in the purchaser's market. Qualcomm Inc. leveraged PBGH's market pricing data as a key additional input, allowing a more rigorous evaluation of carriers and TPAs and strengthening its procurement process.

While Qualcomm Inc.'s experience is illustrative, other large purchasers, such as Costco Wholesale Corporation, The Boeing Company, and the City and County of Denver, were able to identify specific market opportunities for their populations. As this work expands in future iterations, purchasers can explore additional use cases to design benefits strategies that more effectively balance affordability, quality, and value.

¹⁴ In the first phase of the PBGH Health Care Data Demonstration project, this specifically includes Costco Wholesale Corporation, the City and County of Denver, and other large self-funded employers.

6. Policy Implications and Regulatory Recommendations

Critical Data Access Barriers

As discussed, barriers to access and utility of the transparency data persist. In many cases, both hospitals and health plans need to refine their reporting systems and address current limitations to meet the intent of federal rules. This should also be done with the customer in mind to ensure that transparency files meet customer needs. Stronger federal enforcement combined with customer demand is likely to drive improved utility.

But transparency data was not the only data access challenge. Despite clear federal statutory mandates under EMTSA and the Public Health Service Act,¹⁹ as well as subregulatory guidance from the Administration,²⁰ purchasers continue to face significant barriers to accessing their own health care claims data. One purchaser participating in the data project spent more than 10 months resolving access disputes over their own health care claims data, delaying analysis and undermining the goals of the federal transparency initiatives.

Service providers frequently challenged purchasers' rights to access their own data. Some argued that once data entered their systems, it became proprietary. Others pointed to provider contracts that included explicit prohibitions on data sharing, such as barring purchasers from comparing carrier/service provider performance or using data for plan management. These positions directly conflict with the intent of the transparency regulations, the statutory prohibition on "gag clauses" in the CAA,²¹ and may even be inconsistent with the Health Insurance Portability and Accountability Act ("HIPAA").²²

Direct engagement with carrier/TPA/service provider legal counsel revealed resistance to changing business practices, with fundamental disagreements about statutory interpretation. Even when access was eventually granted, it

was sometimes accompanied by restrictive disclosure requirements, lengthy delays, and significant legal costs for purchasers. These obstacles can reduce the data's utility for strategic decision-making and may increase fiduciary risks for purchasers.

Regulatory Enhancement Recommendations

Based on our analysis, several regulatory enhancements would significantly improve the effectiveness and enforceability of the federal price transparency rules:

Data Standardization. Current regulations permit service providers to publish MIFs that technically comply with disclosure requirements but are analytically unusable. Stronger requirements for data formatting, indexing, and accessibility would significantly improve utility without imposing undue burden on reporting entities.

Custom Code Restrictions. Hospitals and service providers frequently publish proprietary or custom billing codes rendering external interpretation impossible. Regulators should require the use of standard code sets whenever available, and strictly define how custom codes must be reported when no standard exists.

Prescription Drug Integration. Physician-administered drugs appear inconsistently in HPT files, and comprehensive pharmaceutical pricing data remains absent from the TIC files. Fully implementing transparency requirements to include prescription drug pricing is essential for purchasers to manage a major driver of health care costs.²³

¹⁹ 42 U.S.C. §§ 2001a-2004.

²⁰ 45 CFR § 94.100 of the HHS's Privacy Rule permits an employee, in a covered entity, to use their claims data for several reasons related to "health care operations," which are set forth in § 94.104(d).

²¹ 42 U.S.C. § 1395bb(a)(1)(A)(ii). The Administration's MIFs under the Transparency Rule are implementing this prohibition on gag clauses as of July 2020.

²³ 45 CFR § 94.100 of the HHS's Privacy Rule permits an employee, in a covered entity, to use their claims data for several reasons related to "health care operations," which are set forth in § 94.104(d).

7. Limitations and Future Research Directions

This analysis represents an initial exploration of the potential of health care transparency data, rather than a comprehensive assessment of all its possible applications. Several limitations should guide the interpretation of findings and inform priorities for future research:

- Sample limitations.** While participating purchasers represented diverse industries and geographies, they constituted a relatively small group of sophisticated and forward-thinking purchasers that might not fully represent the broader purchaser population. Similarly, the regional focus on 10 markets provided analytical depth, but limited generalizability to other geographic areas with different market dynamics.
- Directional utility.** Notwithstanding the aforementioned data limitations, the findings and underlying analysis provide directionally useful insights to inform purchasing strategies and tactics. PBGH continues to build on the dataset developed in this phase of research, and will share additional findings as the project expands.
- Data usability evolution.** Reporting practices may improve over time as payers and hospitals improve their adherence to transparency requirements, and as enforcement becomes more consistent. This study's analytical framework is comprehensive. However, it represents just one of many possible approaches for integrating transparency and quality data.
- Future research priority.** Additional work should expand analysis to a broader set of purchasers and geographic markets, test alternative analytical methodologies, and track longitudinal improvements in both data usability and market responses to increased transparency. Such studies will be essential to assess whether transparency regulations are achieving their intended policy objectives.



8. Conclusions and Implications for Health Care Markets

Our analysis demonstrates that federal health care price transparency regulations have created valuable data resources that, when effectively analyzed, can support more sophisticated and value-based purchasing strategies. Historically, self-insured purchasers lacked the information needed to determine whether they were paying fair prices for high-quality services. Despite spending billions of dollars annually on health care and health benefit consultants, the opacity of actual prices and quality performance has constrained informed decision-making. While some industry actors may seek to use price transparency to raise prices,¹⁷ self-insured purchasers have strong incentives to use the data to select high-value partners and drive affordability in health care.

The findings reveal both the promise and the limitations of current transparency requirements. On one hand, usable pricing data now exists in many markets, offering a foundation for more competitive markets. On the other hand, realizing this potential requires significant analytical infrastructure to transform raw machine-readable files into usable insights. The lack of correlation between price and quality, combined with wide and seemingly arbitrary price variation, underscores that health care markets do not function according to conventional economic logic. Transparency requirements provide a pathway to correct this dysfunction, but only if barriers, such as data access restrictions imposed by carriers and TPAs, are addressed.

For self-insured purchasers, the PBGH data project offers a roadmap for using transparency data to meet fiduciary obligations, strengthening oversight, and identifying cost reduction opportunities without compromising quality. However, the technical complexity of analyzing transparency files means most purchasers will need either to build internal analytical capacity or partner with specialized firms. To date, few, if any, firms serving self-insured

employers have developed these capabilities. Industry practices will need to evolve towards models that emphasize actual prices and outcomes and move away from TPA discount analyses that do not show relative pricing.

Regulatory enhancements are essential to maximize the impact of transparency initiatives. Most carriers and service providers are technically compliant with existing rules, but compliance is oriented towards meeting the bare minimum rather than practical utility for purchasers and patients. Aligning federal regulations more closely with purchaser information needs, through stronger data standardization, improved access rights, and robust enforcement, would dramatically improve the effectiveness of the current transparency framework, without fundamentally altering the regulatory framework.

Most importantly, this project proves that rational health care purchasing decisions become possible when comprehensive price and quality data are properly integrated and analyzed. Like in other industries, competition can drive efficiency once information asymmetries are reduced. Overcoming entrenched opacity and “black box” pricing practices could allow health care markets to function more like other economic sectors, delivering affordability and value. For America’s working families, who ultimately bear the costs of inefficiency through reduced wages and higher out-of-pocket costs,¹⁸ the stakes of realizing this potential could not be higher.

* For example, one of the most foundational and widely cited economic papers of all time by Kenneth Arrow, “Uncertainty, the Welfare Economics of Medical Care” (1958), is widely recognized as so fundamentally different than other markets that health care is a classic case of market failure and, as a result, cannot be expected to obey normal economic laws. The prevailing wisdom among academics like Arrow is largely followed this presumption to fault – depriving health care markets of a well-chosen set of being functional, competitive, transparent, and responsive to the needs of purchasers and consumers.

9. Endnotes

- 1 CMS (N.D.) "Hospital Price Transparency" Initiatives [\[Link\]](#) (last modified 5/22/2025)
- 2 CMS (N.D.) "Transparency in Coverage" Initiatives [\[Link\]](#) (last modified 8/14/2025)
- 3 PBCH and our data project partners adhered to strict data privacy standards throughout the project, ensuring that patient and data privacy were prioritized and protected at all times. PBCH did not receive personal health information ("PHI") at any point during the project.
- 4 Tri-Agencies (Nov. 12, 2020) "Transparency in Coverage Final Rule" *Federal Register*, Vol. 85, No. 219 [\[Link\]](#) at p. **72208**
- 5 For an overview of the legal risk that fiduciaries face, see PBCH's March 2025 [policy issue brief](#); generally and, more specifically, the four class action lawsuits that purchasers are facing over (allegedly) paying excessive health care fees: (1) [Levante-Owasi v. Johnson & Johnson](#) (1/7/24), [S.M.O. v. Mayo Clinic](#) (4/2/2024), [Navarro et al. v. Wells Fargo](#) (7/30/24), and [Stern et al. v. PricewaterhouseCoopers](#) (5/13/2025).
- 6 U.S. CMS (Apr. 11, 2025) "Wage Index" [\[Link\]](#) ("Section 1886(d)(3)(B) of the Social Security Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts 'for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'")
- 7 See e.g., Gaynor (2018) "Examining the Impact of Health Care Consolidation" House Energy and Commerce Committee Testimony [\[Link\]](#) ("Extensive research evidence shows that consolidation between close competitors leads to substantial price increases for hospitals, insurers, and physicians, without offsetting gains in improved quality or enhanced efficiency"); Goldsmith et al. (Feb. 2015) "Integrated Delivery Networks: In Search of Benefits and Market Effects" *National Academy of Social Insurance* [\[Link\]](#) (Finding that there is "no difference in clinical quality or safety scores" between Integrated Delivery Networks and their in-market competitors); and Burke and Ryan (Feb. 2014) "The Complex Relationship Between Cost and Quality in US Health Care" *AMA Journal of Ethics*, Vol. 16, No. 2 [\[Link\]](#)
- 8 See e.g., Schwartz et al. (Sep. 2020) "What We Know About Provider Consolidation" *AFJ* [\[Link\]](#) and Liu et al. (Sep. 2022) "Environmental Scan on Consolidation: Trends and Impacts in Health Care Markets" *RAND* [\[Link\]](#) (Finding "strong evidence that hospital horizontal consolidation is associated with higher prices paid to providers and some evidence of the same for vertical consolidation of hospitals and physician practices. Health care spending is likely to increase in tandem with these price increases.")
- 9 Guadado and Kane (Nov. 2024) "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2024 update)" *American Medical Association*, 25th Edition [\[Link\]](#)
- 10 *Ibid.*
- 11 Specifically, the obligation under ERISA is for employers to purchase and provide high-quality benefits "solely in the interest" of plan participants at "only reasonable expense." While public entities are not subject to ERISA, similar fiduciary standards frequently apply to trustees of public sector benefit plans – so the need to manage health care costs prudently exists for all purchasers.
- 12 Tri-Agencies (Nov. 12, 2020) "Transparency in Coverage Final Rule" *Federal Register*, Vol. 85, No. 219 [\[Link\]](#) at p. **72208**
- 13 The CMA's big clause prohibition under CAA § 201, modifying PHSA § 2799A-9 and ERISA § 724 [\[Link\]](#) at pgs. 2890 – 2894.
- 14 For the Administration's FAQ guidance on big clause prohibition implementation, see the tri-agencies' FAQ 37 [\[Link\]](#) and, more recently, FAQ 69 [\[Link\]](#)
- 15 CAA § 201 [\[Link\]](#) at pgs. **2890** and **2891**.
- 16 U.S. CMS, DOL, and the Treasury (Jan. 14, 2025) "FAQs about Consolidated Appropriations Act, 2021 Implementation Part 69" [\[Link\]](#)

- 17 See e.g., Trek Health (N.D.) "Unlocking Better Reimbursements: How Providers Can Use Payer Transparency Data" [\[Link\]](#) ("Providers should thoroughly evaluate their rates against prevailing industry standards to identify areas where their services may be undervalued. For instance, a hospital specializing in diabetes treatment may find through transparency data that their regional rates are lower than those of competitors. By presenting this insight during negotiations, the provider could substantiate a request for higher reimbursement rates"); Long Delio (Apr. 29, 2025) "Payer Price Transparency: Use It to Increase Rates & Revenue" *MD Clarity, Revenue Cycle Management* [\[Link\]](#); and Daly (Jul. 7, 2025) "Providers Urged to Leverage Data and Strategy for Successful Payer Negotiations" *HFMA* [\[Link\]](#)
- 18 See e.g., Hager et al. (January 2024) "Employer-Sponsored Health Insurance Premium Cost Growth and its Association with Earnings Inequality Among U.S. Families," *JAMA Network Open*, Vol. 7, No. 1 [\[Link\]](#) and Arnold and Whaley (Jul. 2020) "Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages" *BAND* [\[Link\]](#)

About the Purchaser Business Group on Health (PBGH)

Purchaser Business Group on Health (PBGH) is a nonprofit coalition representing 40 private employers and public entities across the U.S. that collectively spend \$350 billion annually purchasing health care services for more than 21 million Americans and their families. PBGH has a 35-year track record of incubating new, innovative operational programs in partnership with large employers and other health care purchasers. Our initiatives are designed to test innovative methods and scale successful approaches that lower health care costs and increase quality across the U.S.

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11. Appendices

Appendix 1: List of Metropolitan Statistical Areas, Hospitals, and Payer Networks in Each Regional Market

This appendix lists some of the considerations for the inclusion and exclusion for each of the 10 regional markets, including the Metropolitan Statistical Areas (MSAs), major hospitals/health systems, and the large carriers, sometimes referred to as group payers or third-party administrators (TPAs).

Many of the carriers offer multiple networks in the regional markets, including both PPOs and HMOs. Some of these organizations may have narrow or high-performance networks, which are not considered in this analysis.

Regional Market 1 – Seattle/Puget Sound

This regional market includes price transparency data for two MSAs in Washington (WA) – Seattle-Bellevue-Kent, WA and Tacoma-Lakewood, WA. Major hospitals and health systems in the region include:

- CommonSpirit Health
- MultiCare Health System
- Providence
- Seattle Children's
- University of Washington Medicine

There are also a number of public hospital district facilities in this region, including EvergreenHealth facilities, Snoqualmie Valley Hospital, and Valley Medical Center.

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Premiera Blue Cross	Premiera Heritage
Regency Blue Shield	Regence Preferred
Cigna	Cigna OAP
Kaiser	Excluded due to lack of sufficient transparency data
UnitedHealthcare (UHC)	UHC Choice Plus

Regional Market 2 – Oregon

This regional market includes price transparency data for the entire state of Oregon. Major hospitals and health systems in the region include:

- Adventist Health Portland
- Asante
- Kaiser Permanente
- Legacy Health
- Oregon Health & Science University
- PeaceHealth
- Providence
- Salem Health
- St. Charles Health System, Inc.

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Asuris	Excluded given they submitted the same MRFs as Regence Blue Cross Blue Shield and both are operated by Cambia Health
Cigna	Cigna OAP
Kaiser	Excluded due to lack of sufficient transparency data
Moda	Moda Comexus
Providence	Providence Choice
Regence Blue Cross Blue Shield	Regence Preferred
UnitedHealthcare (UHC)	UHC Choice Plus

Regional Market 3 – Northern California

This regional market includes price transparency data for a number of MSAs in Northern California. This paper covers the entire state of California with MSAs categorized into Northern or Southern regions. Please note this split is an approximation and is not based on any official definition, and all MSAs are included in one of the two regions. For purposes of the analysis, the California Non-MSA Area was placed with Northern California results. The Northern California regional market includes the following MSAs:

- Chico, CA
- Fresno, CA
- Merced, CA
- Modesto, CA
- Napa, CA
- Non-MSA Area, CA
- Oakland-Berkeley-Livermore, CA
- Redding, CA
- Sacramento-Roseville-Folsom, CA
- Salinas, CA
- San Francisco-San Mateo-Redwood City, CA
- San Jose-Sunnyvale-Santa Clara, CA
- San Rafael, CA
- Santa Cruz-Watsonville, CA
- Santa Rosa-Petaluma, CA
- Stockton, CA
- Vallejo, CA
- Yuba City, CA

Major hospitals and health systems in the region include:

- Adventist Health
- CommonsSpirit Health (includes Dignity Health facilities)
- John Muir Health
- Kaiser Permanente
- Stanford Health Care (includes Lucile Packard Children's Hospital)
- Sutter Health
- University of California (UC) Davis
- UC San Francisco

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Anthem	Anthem PPO
Blue Shield of CA	Blue Shield of CA Full PPO
Cigna	Cigna OAP
Kaiser	Excluded due to lack of sufficient transparency data and insufficient Kaiser hospital data for its PPO networks
UnitedHealthcare (UHC)	UHC Choice Plus

The Anthem product included in the study varies from region to region. Please note that the analysis in California focuses on the Anthem PPO given it seems to be the primary group network based on the number of employers associated with the PPO MRGs for California.

Regional Market 4 – Southern California

This regional market includes price transparency data for a number of MSAs in Southern California. This paper covers the entire state of California with MSAs categorized into Northern or Southern regions. Please note this split is an approximation and is not based on any official definition, and all MSAs are included in one of the two regions. For purposes of the analysis, the California Non-MSA Area was placed with Northern California results. The Southern California regional market includes the following MSAs:

- Anaheim-Santa Ana-Irvine, CA
- Bakersfield, CA
- El Centro, CA
- Hanford-Corcoran, CA
- Los Angeles-Long Beach-Glendale, CA
- Oxnard-Thousand Oaks-Ventura, CA
- Riverside-San Bernardino-Ontario, CA
- San Diego-Chula Vista-Carlsbad, CA
- San Luis Obispo-Paso Robles, CA
- Santa Maria-Santa Barbara, CA
- Visalia, CA

Major hospitals and health systems in the region include:

- Adventist Health
- Cedars-Sinai Health System
- CommonSpirit Health (includes Dignity Health facilities)
- Keck Medicine of USC (University of Southern California)
- Loma Linda University Health
- Providence
- Scripps Health
- Sharp HealthCare
- UC San Diego
- UC Los Angeles (UCLA) Health

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Anthem	Anthem PPO
Blue Shield of CA	Blue Shield of CA Full PPO
Cigna	Cigna OAP
Kaiser	Excluded due to lack of sufficient transparency data and insufficient Kaiser hospital data for its PPO networks
UnitedHealthcare (UHC)	UHC Choice Plus

The Anthem product included in the study varies from region to region. Please note that the analysis in California focuses on the Anthem PPO product given it seems to be the primary group network based on the number of employers associated with the PPO MRFs for California.

Regional Market 5 – Phoenix

This regional market includes price transparency data for the Phoenix-Mesa-Chandler, Arizona (AZ) MSA. Major hospitals and health systems in this regional market include:

- Banner Health
- CommonSpirit Health (includes Dignity facilities, Chandler Regional Medical Center, Mercy Gilbert Medical Center, St. Joseph's Hospital and Medical Center)
- HonorHealth
- Mayo Clinic Phoenix
- Phoenix Children's Hospital
- Tenet Healthcare Corporation (includes Abraszo facilities)

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna (including Banner/Aetna joint venture)	Aetna Choice POS II
Blue Cross and Blue Shield of Arizona (BCBS AZ)	BCBS AZ Satewide PPO
Cigna	Cigna OAP
UnitedHealthcare (UHC)	UHC Choice Plus

Regional Market 6 – Denver

This regional market includes price transparency data for the Denver-Aurora-Lakewood, Colorado (Denver) MSA. Major hospitals and health systems in the regional market include:

- AdventHealth
- Children's Hospital Colorado
- CommonSpirit Health
- Denver Health and Hospital Authority
- HCA HealthONE (Includes Presbyterian St. Luke's Medical Center, Swedish Medical Center, Sky Ridge Medical Center, The Medical Center of Aurora)
- Intermountain Healthcare
- UCHHealth

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Anthem	Anthem PPO
Cigna	Cigna PPO
Kaiser	Excluded due to lack of sufficient transparency data
UnitedHealthcare (UHC)	UHC Choice Plus

The Anthem product included in the study varies from region to region. Please note that the analysis in Denver focuses on the Anthem EPO product given it seems to be the primary group network based on the number of employers associated with the PPO MRs for Colorado. Cigna PPO network was used in this regional market instead of Cigna OAP as the OAP files included very limited data in Denver. Across the country, the Cigna PPO and OAP networks tend to have the same rates at most facilities.

Regional Market 7 – Dallas

This regional market includes price transparency data for the Dallas-Plano-Irving, Texas (Dallas) MSA. Major hospitals and health systems in the region include:

- Baylor Scott & White Health
- Children's Health
- HCA Healthcare (includes Medical City facilities)
- Methodist Health System
- Parkland Health
- Southwestern Health Resources

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Baylor Scott & White Health Plan	Excluded due to lack of sufficient transparency data
Blue Cross and Blue Shield of Texas (BCBS TX)	BCBS TX Blue Choice PPO
Cigna	Cigna OAP
UnitedHealthcare (UHC)	UHC Choice Plus

Regional Market 8 – Chicago

This regional market includes price transparency data for the Chicago-Naperville-Evanston, Illinois (Chicago) MSA. Major hospitals and health systems in the region include:

- Advocate Health
- Ann & Robert H. Lurie Children’s Hospital of Chicago
- Ascension Illinois
- Cook County Health
- Endeavor Health
- Northwestern Medicine
- Rush University System for Health
- Trinity Health
- UChicago Medicine AdventHealth

Other important facilities include University of Illinois Hospital and Clinics, Swedish Hospital, and Silver Cross Hospital and Medical Centers.

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Blue Cross and Blue Shield of Illinois (BCBS IL)	BCBS IL Participating Provider Options
Cigna	Cigna OAP
UnitedHealthcare (UHC)	UHC Choice Plus

Regional Market 9 – Atlanta

This regional market includes price transparency data for the Atlanta-Sandy Springs-Alpharetta, Georgia (GA) MSA. Major hospitals and health systems in the region include:

- Emory Healthcare
- Grady Health System (includes Children’s Healthcare of Atlanta)
- Northside Hospital System
- Piedmont Healthcare
- Tanner Health System
- Wellstar Health System

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Anthem	Anthem POS
Cigna	Cigna OAP
Kaiser	Excluded due to lack of sufficient transparency data
UnitedHealthcare (UHC)	UHC Choice Plus

The Anthem product included in the study varies from region to region. Please note that the analysis in Atlanta focuses on the Anthem POS product given it seems to be the primary group network based on the number of employers associated with the POS MRFs compared to other products such as the PPO. In other regional markets, the PPO or EPO products appear to have the largest group enrollment.

Regional Market 10 – New York City/Northern New Jersey

This regional market includes price transparency data for the New York-Jersey City-White Plains, NY-NJ (New York City) MSA. Major hospitals and health systems in the region include:

- Hackensack Meridian Health
- Montefiore Health System
- Mount Sinai Health System
- New York City Health and Hospitals Corporation
- NewYork-Presbyterian
- Northwell Health
- NYU Langone Health System
- RWJ Barnabas Health

The major large group payers/TPAs, and their broadest group network that the analysis was focused on were:

Group Payer/TPA	Network Used for Analysis
Aetna	Aetna Choice POS II
Anthem (includes legacy Empire BCBS plans)	Anthem PPO (same as Empire PPO)
Cigna	Cigna OAP
EmblemHealth	EmblemHealth National / Bridge
Horizon BCBS NJ	Horizon BCBS NJ Managed Care
UnitedHealthcare (UHC)	UHC Choice Plus

The Anthem product included in our study varies from region to region. Please note that the analysis in New York City/Northern New Jersey focuses on the Anthem PPO product given it seems to be the primary group network based on the number of employers associated with the PPO MRFs compared to other products. Empire was acquired by Anthem as of January 1, 2024, but many of the Empire networks are still available under the Anthem brand. There appeared to be three main Anthem networks for large employers in New York City. They are listed below from most narrow to most broad:

- Connection
- Blue Access
- EPO / PPO

Appendix 2: More Details on Data Usability Methodology

The Percent of Expected, the primary metric used in the Data Demonstration Project to measure data completeness and usability, is critical when analyzing results, however, it is not intended to be a measure for assessing compliance with the HPT and TIC requirements. The Percent of Expected reflects how readily usable the transparency data is for the purpose of PBGHIS Data Demonstration Project.

We found varied levels of data completeness and usability across regional markets, carriers, networks, providers, places of services, procedures and diagnostic conditions. We also found that sometimes the HPT and TIC data was reported for compliance purposes and lacked usability from purchaser's perspectives. For these reasons, it is imperative to cross-check data from different sources and against expert knowledge in health care contracting. There are gaps and opportunities for further improvement in how data is reported as well as for policy makers to update regulations and/or provide more clarity and rigor in data and reporting requirements.

Section A – Review of Scenarios of Data Usability or The Lack of

I. When Percent of Expected or Expected Data Usability is High

Instances have been observed where the posted transparency data is relatively complete, but the data may not be accurate or reliable for various reasons, for example, multiple rates were posted for the same provider under the same network for the same procedure. Even when the Percent of Expected value is high, it is still important to evaluate the reasonableness of the results.

II. When Percent of Expected or Expected Data Usability is Low or Zero

There still could be meaningful, compliant data in the posted transparency files, the Machine Readable Files ("MRFs"). For example:

1. **Percent of Charge Contracts - Generally Not Usable to Derive Allowable Amount / Negotiated Rate (Unless Billed Charge Amount is Reported or Available in Other Data Sources, But Might Still Have Other Utility).**

In the TIC data, payers are allowed to report a percent of charge as their method to determine negotiated rates (e.g., the negotiated rate is 50% of billed charges). However, unless there is a known billed charge amount - which is not a required element in the TIC data - it is not possible to calculate a negotiated rate and, therefore, not a usable data point for comparing contracted rates unless other payers have also posted percent of charge values. In this instance, other data sources are evaluated to fill the gap.

- a. The HPT data does require billed charges, which may be used, where available, to derive an allowed amount / negotiated rate. For this study, the derived value is included in the estimation of Percent CRVU Medicare, hence the Percent of Expected or data usability increases.
- b. When the HPT data is also missing the billed charges, the negotiated rate cannot be estimated, hence the Percent of Expected or data usability could be low even when there is compliant data available in the MRFs.
- c. However, such data may still be usable for ad hoc analysis, for instance, for comparisons when multiple payers have a percent-of-charge contract with a provider, and vice versa.

2. **Non-Standard Codes for Contract Negotiation – Usability Varies and Dependent on Validation from Other Sources**
- There are many different types or sets of codes that may be utilized in payer / provider contracts. These analyses accounted for many of these standard code types (e.g., Revenue Code, HCPCS, MS-DRGs, APR-DRGs, APCs). However, the posed transparency data includes, in some cases, other non-standard code types, for example:
- Valid code types.** Valid codes include, but are not limited to, EAPGs, NDCs, ICD-10s, and CDTs. When supporting rate information for these code types is absent, they are excluded from the aggregated relativities and Percent of Expected metrics for this study.
 - Custom codes.** Payers also report custom codes in the transparency files data across the country. The use of custom codes is permitted under both HPT and TIC schemas if there is not a standard code available to describe a particular service. Additionally, in the TIC data, payers are also permitted to use a code type value of CSTM-ALL with a billing code of CSTM00 if every service is reimbursed at the same rate (such as a uniform percent-of-charge contract), rather than listing out the same value for all possible codes. Since there is often no standard definition of the services included in custom codes, and payers sometimes post multiple rates under CSTM00 for the same provider, it can be difficult to derive a negotiated rate for specific procedures. Therefore, the usability of this data is often limited.
3. **Non-Standard Data Format Reported in The HPT Data Limits Data Usability**
- In some cases, hospitals post data in an unusable format under the current HPT schema. For example, the current HPT schema assumes all negotiated rates fall under one of three categories:
- Dollar Amount
 - Percentage Rate
 - Standard Algorithm
- Under the regulations, hospitals should report an estimated allowed amount for rates reimbursed as a percentage or algorithm to provide some comparable cost information in dollars. The estimated allowed amount should reflect the average reimbursement amount in dollars based on historical claims for services reimbursed as a percentage rate or algorithm.
- Several hospitals only provided data for the estimated allowed amount field and did not report any dollar or percentage rates. When this occurs, it is not always clear if (i) the reported data / value is reimbursed based on a particular algorithm, (ii) the actual negotiated rates are reported in the estimated allowed field, or (iii) the information is missing altogether. As a result, the data is not usable to be included in the estimations of GRVU Medicare or Percent of Expected metrics.
- However, due to the frequency of this issue, updates to the transparency data processing logic to utilize the estimated amounts in absence of negotiated rates are being evaluated. This could improve the usability of some of the HPT data, assuming these estimated amounts are a reasonable proxy for negotiated rates.
- Additionally, CMS has noted that this structure might be a barrier to transparency data analytics in the CY 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule. CMS is currently seeking comments regarding how to address this issue.
4. **Missing or Imprecisely Categorized Data.**
- In some cases, payers or hospitals fail to include, in their transparency files, some key information (e.g., provider information) or imprecisely report certain data (e.g., labeling facility rates as professional, not including the Severity of Illness (SOI) value for APR-DRGs). In these instances, some otherwise usable data may be excluded in the aggregated relativities and estimation of Percent of Expected or data usability.

Section B – Illustration of Data Usability Challenges

This section illustrates few examples of data usability challenges commonly encountered in this study, including payer data posted by four major carriers as well as hospital-posted data.

I. Payer Data – Banner – University Medical Center Phoenix As An Example

To illustrate the above points in more detail, let's deep dive into TIC data for Banner - University Medical Center Phoenix to highlight how the different ways the data is posted impact the data usability.

The Percent of Expected results are very strong for all four payers (Aetna, BCBS AZ, Cigna and UnitedHealthcare ("UHC")) for facility inpatient ("FIP") services and well above 75%. As a result, the inpatient data appears to be usable for aggregated cost comparisons.

On the other hand, on a Percent of Expected basis, the facility outpatient ("FOP") results are mixed indicating the data is potentially less usable. However, upon a closer look at the code level data, one can gain additional insight into the categories with a lower Percent of Expected value. The table below summarizes the number of codes by payer network for the three most common code types that both have a negotiated rate within a reasonable range and are included in the high-level summary comparisons (including aggregated Percent of GRVU Medicare metrics and estimation of the Percent of Expected).

	MSDRG	HCPCS	Revenue Code
FIP			
Aetna Choice POS II	743		4
Cigna OAP	708		17
BCBS AZ Statewide PPO	743		
UHC Choice Plus	742		23
FOP			
Aetna Choice POS II		6,019	1
Cigna OAP		2,136	1
BCBS AZ Statewide PPO		7,081	
UHC Choice Plus		3,724	

The table above shows that the FIP data is consistently reported with a nearly full set of MS-DRG codes available for comparison from all four payers.

There is much more variability on the FOP side, as Cigna and UHC have fewer HCPCS codes that are considered usable. It is not clear from the code counts if the data is excluded by the rate reasonability algorithm or posted in some other format that does not permit aggregating such as the use of custom codes as described above.

Furthermore, to better understand the posted data, we also need to review the data that is excluded for each payer network to determine if there is usable information, as there is often usable information at the code level even when the Percent of Expected metric is low.

Aetna Choice POS II

Based on the volume of codes present in the data, Aetna appears to have posted a full fee schedule of services including many services that are not considered common procedures at this type of facility and can be referred to as "ghost rates."

More interestingly, Aetna appears to have a high proportion of rates that are excluded from the calculations because more than one negotiated rate was submitted for the same provider / network / code / place of service (POS) / modifier combination.

Below is an example for a single colonoscopy code:

Payer	Network Name	Category	Type	Code	Negotiated Type	Amount
Aetna	Choice POS II	FOP	Surgery	HCPCS 45380	Negotiated Fee	\$1,287.00
Aetna	Choice POS II	FOP	Surgery	HCPCS 45380	Negotiated Fee	\$4,521.00
Aetna	Choice POS II	FOP	Surgery	HCPCS 45380	Negotiated Fee	\$6,483.00
BCBS AZ	Statewide PPO	FOP	Surgery	HCPCS 45380	Negotiated Fee	\$4,357.45
United Healthcare	UHC Choice Plus	FOP	Surgery	HCPCS 45380	Negotiated Fee	\$5,105.00

In this example, Aetna posted three different negotiated rates for the same code, while BCBS AZ and UnitedHealthcare have only one rate (as expected). From the data, it is not clear why there are three different Aetna rates nor is it clear which rate is the most appropriate to use.

BCBS AZ Statewide PPO

Similar to Aetna, BCBS AZ appears to have posted a robust fee schedule for this facility and also has many "ghost rates," which are excluded in the aggregations of data. This highlights the importance of utilization values that can more appropriately filter and weight codes that represent likely services for a given provider type.

Cigna OAP

Cigna appears to have reported limited information for outpatient procedures, including surgery and other categories. Only about 2,100 HCPCS were included in the high-level summary analysis. The excluded data showed additional HCPCS as well as two custom codes (CSTM00) with two different percentages of billed charge reimbursement rates of 50% and 69%. In the raw posted TIC data, Cigna denoted the following for the CSTM00 codes:

Billing code	Code Type	Negotiated Type	Negotiated Rate	Additional Information
CSTM00	CSTM-ALL	percentage	50	Inpatient services not otherwise priced
CSTM00	CSTM-ALL	percentage	50	Outpatient services not otherwise priced
CSTM00	CSTM-ALL	percentage	69	Outpatient services not otherwise priced

The inpatient data was well-populated with MS DRGs, so it is likely the 50% rate would not apply in many circumstances. However, the outpatient percent of charge data has limited usability given there are multiple rates, and it is not clear when each rate applies.

UHC Choice Plus

UHC reported limited information for all outpatient categories, except surgery. Only about 3,700 HCPCS were included in the high-level summary analysis.

The excluded data revealed that UHC posted 46 custom codes with different reimbursement rates. Based on the values provided (sample shown below), there are certain cases where standard codes possibly could have been used in place of the custom information. For example, non-standard codes, such as "PTH", "CHM", and "RAD" with corresponding descriptions such as "PHYSICAL THERAPY", "CHEMOTHERAPY", and "RADIATION THERAPY" could potentially have been mapped to a known outpatient code. Since no code sets are published for these descriptions – and some of these descriptions appear to overlap (e.g., EMR vs EMR3) – the data is not widely usable for purchasers.

In Summary

The variety of information provided by each payer highlights some of the challenges of using this data for analytics. Even if all of the data posted above were compliant with the regulations (which is not the intent of this project or publication to validate data compliance), it is harder to interpret and utilize some information than others for purchasers and other stakeholders. The TIC and HPT datasets contain a trove of negotiated rate information, but proper scrutiny and diligence are required to identify data suitable for comparisons. Since Aetna, Cigna, and UHC are national carriers, there are similar themes in their data across all 10 regional markets. Each Blues plan posted their own files, so data usability varies across the 10 regional markets.

Code Type	Code	Rate Methodology	Amount	Percent Rate
Custom	CHM	Negotiated Fee	\$825.00	
Custom	EMG	Percent of Charge		53.40%
Custom	EMR	Negotiated Fee	\$1,887.00	
Custom	MHCD	Percent of Charge		100.00%
Custom	MISC	Percent of Charge		53.40%
Custom	PTH	Negotiated Fee	\$265.00	
Custom	RAD	Negotiated Fee	\$2,420.00	
Custom	TRAU	Negotiated Fee	\$7,439.00	
Custom	TRMT	Percent of Charge		53.40%

II. Hospital Data – No Clear Mapping to Payer and Health Plan Network/Name

The data enrichment process includes an in-depth review of TIC data to identify the specific networks for each payer. However, unlike the TIC data, there is generally not a clean mapping of the required payer and plan names to specific networks in the HPT data.

For example, instead of being able to identify the Aetna Choice POS network, a hospital may indicate the negotiated rate is attributed to "AETNA COMMERCIAL" or "AETNA ALL PRODUCTS." To compare the HPT data to the TIC data, the HPT plan names that appear most consistent with a broad PPO network are selected for the analytics, which may be imperfect but a logical method.

Example – Emory University Hospital

The following table demonstrates the varied health plan names for each of the four commercial payers that Emory University Hospital reported in their transparency files. The analytics of this project focus on broad, commercial PPO plans and include the Plan Names of "PPO" for each carrier. It is also assumed that "BCBS" represents Anthem at this facility. This is a relatively straightforward example of the work that needs to be performed to map networks in the hospital data. In many cases, the actual mapping is far more complex than what this example illustrates.

Payer Name	Plan Name
AETNA	EXCHANGE
AETNA	HMO/POS
AETNA	MEDICARE MANAGED CARE PLAN
AETNA	PPO
AETNA	WHOLE HEALTH HPN
BCBS	BLUE VALUE SECURE MEDICARE MANAGED CARE PLAN
BCBS	HMO
BCBS	HPN OTHER COMMERCIAL PLAN
BCBS	PATHWAYS OTHER COMMERCIAL PLAN
BCBS	PPO
CIGNA	HEALTHSPRING MEDICARE MANAGED CARE PLAN
CIGNA	HMO/POS
CIGNA	PPO
UNITEDHEALTHCARE	CORE/CHARTER/NEXUS OTHER COMMERCIAL PLAN
UNITEDHEALTHCARE	HMO
UNITEDHEALTHCARE	MEDICARE MANAGED CARE PLAN
UNITEDHEALTHCARE	PPO

III. Hospital Data – Commonly Posted “Estimated Allowed Amount” without the “Negotiated Rate or Percentage”, Resulting in More Data Usability Challenges

This is another common challenge in hospital data usability seen across all ten (10) regional markets in this study. To use the posted estimated allowed amounts for analysis, one would need to assume they are accurate representation of negotiated rates. Under this assumption, the Percent of Expected or data usability would likely appear much higher. However, it is difficult to understand the negotiated rates with the information provided. It is also unclear whether the posted estimated allowed amounts are truly an accurate representation of negotiated rates.

Example 1 – Emory University Hospital

Emory did not post a negotiated rate or negotiated percentage for any codes for the Aetna and UHC PPOs. Instead, they populated the estimated allowed, minimum/maximum standard charge fields, and included the description “Conditional payment logic at the claim level including numerous contracting methods, hierarchical applications, and service utilization requirements” as the negotiated algorithm for every code. Without more information about how these estimated allowed values were generated, it would be difficult to use this data in analysis unless one were to rely solely on the estimated allowed amounts.

For the Cigna PPO, Emory posted all rates as reimbursed at 72.00% of billed charges.

For BCBS PPO, the FIP rates were posted as reimbursed at 83.72% of billed charges while the FOP rates only included the estimated allowed and minimum/maximum standard charge fields. However, billed charges for any of the FIP codes appeared absent. Therefore, it was not possible to derive negotiated rates for the FIP values.

Example 2 – Tanner Medical Center – Carrolton

Tanner Medical Center – Carrolton reported majority of rates being reimbursed as a percentage of billed charges for all four payers. However, no percentage rates or negotiated rates were included for any contracts while the estimated allowed and minimum/maximum standard charge fields were available.

Example 3 – Wellstar Kennestone Regional Medical Center

Wellstar Kennestone Regional Medical Center did not report percentage rates or negotiated rates for the four payers included in this study. Like others in this region, Wellstar included the estimated allowed and minimum/maximum standard charge fields and the following comment for every rate in the “additional_generic_notes” field:

“Contracting method is an algorithm described in the ‘standard_charges/algorithm’ field. The estimated allowed amount provided accounts for the structural rates, conditions, and utilization elements inherent in the payers algorithm.”

It is assumed that the ‘standard_charges/algorithm’ field represents the ‘negotiated algorithm’ field, which has the following value for each record:

“Conditional payment logic at the claim level including numerous contracting methods, hierarchical applications, and service utilization requirements.”

Conclusion

Having access to price transparency data is a great starting point. However, to ensure beneficial utility for health care purchasers, it requires more thoughtful planning, rigorous data aggregation and analysis; integration with other data sources such as quality data, expert advisory guidance, data reporting from purchasers’ perspectives and not just checking the compliance box, as well as more clarification from policy makers on data and reporting requirements. PRGH’s Data Demonstration Project demonstrated that it is possible, yet there is a lot more to be done.

Appendix 3: Usability of TIC Files by Regional Market

A high-level summary of data usability by hospital for the TIC data submitted by payers based on the Percent of Expected Metrics are summarized below. Please note these tables only reflect facility inpatient and facility outpatient data. There was far more variation in the usability of negotiated facility rates than professional fees within the MREs, so figures corresponding to this section focus on the former.

Seattle/Puget Sound's tables were used in the body of the report as examples and not included again in the appendix. All payer (TIC) data used for these illustrations was from the time period of March 2025 to June 2025. The posted price transparency data is being updated continuously, and it is possible that some of the figures in this report will not match more recently posted information.

Each of the tables also includes the Leapfrog Hospital Safety Grade as of Spring 2025. The Leapfrog Hospital Safety Grade Program grades hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. For more information visit www.hospitalgrade.org.

* The Leapfrog Group data used in this display undergoes rigorous verification and quality control processes (see the Leapfrog Hospital Survey, Leapfrog ASC Survey, and the Hospital Safety Grade) and stands behind its methodology. However, as with any data source, the Leapfrog Group cannot warrant or endorse the methodology used by users, end users, and/or third party vendors incorporating Leapfrog data in their own displays. Therefore, Leapfrog does not warrant or endorse the accuracy, reliability, completeness, timeliness or appropriateness of any data in this display and therefore shall not be held liable for any losses or damages caused by reliance on this display.

Oregon — Lower Data Usability Than Other Regional Markets

The data usability in Oregon is lower than other regional markets included in this analysis based on the Percent of Expected metric. Regence has the most facilities that meet the highest threshold (>75%) based on the Percent of Expected metric, but there are many facilities where meaningful comparisons with the data may be more challenging. However, the usability does appear to be stronger at the larger facilities in Oregon, such as Adventist Health Portland, Legacy Emanuel Medical Center, OHSU Hospital and Clinics, Providence Portland Medical Center, etc.

Oregon Payer Transparency Data	Leapfrog Hospital Safety Score		Aetna Hospital POS II		Cigna Signal GAP		Meds Compass		Providence Health Plan Signals		Regence ECRS Regions Retired		UnitedHealthcare UHS Signal Plus	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Adventist Health Portland	C													
AdventistHealth Tillamook	N/A													
Asante Ashland Community Hospital	N/A													
Asante Rogue Regional Medical Center	C													
Asante Three Rivers Medical Center	A													
Bay Area Hospital	D													
Blue Mountain Hospital	N/A													
CHI St. Anthony Hospital	N/A													
Columbia Memorial Hospital	F													
Coquille Valley Hospital	N/A													
Curry General Hospital	N/A													
Good Samaritan Regional Medical Center	C													
Good Shepherd Health Care System	N/A													
Grande Ronde Hospital	N/A													
Harney District Hospital	N/A													
Hillsboro Medical Center	D													
Lake District Hospital	N/A													

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Percent of Expected: ● 0-25% Generally unusable Recommendation: code-level investigation ● 26-50% Moderately usable Recommendation: additional investigation ● 51-75% Generally usable Recommendation: additional investigation ● 76-100% Highly usable

Oregon Payer Transparency Data		Leapfrog Hospital Safety Score		Aetna COPD POP II		Cigna OptiMAP		Moda Optima		Providence Health Plan		Regence ECRS		UnitedHealthcare	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Legacy Emanuel Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Good Samaritan Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Meridian Park Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Mount Hood Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Salmon Creek Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Silverton Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Lower Umpqua Hospital District	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Molenzie-Willamette Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Mercy Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Mid-Columbia Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Ohsu Hospital and Clinics	D	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Peace Harbor Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth — Sacred Heart Medical Center University District	D	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth — St. Joseph's Community Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth Sacred Heart Medical Center at RiverBand	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth Southwest Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Pioneer Memorial Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Hood River	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Joseph	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Medford Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Milwaukie Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Newberg Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Portland Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Seaside Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Mary Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Vincent Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Providence Willamette Falls Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●	●	●

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Percent of Expected: ● 0-25% Generally unable to recommend cost-level investigation ● 26-50% Moderately unable to recommend additional investigation ● 51-75% Generally usable consider additional investigation ● 76-100% Highly usable

Oregon Payer Transparency Data	Leapfrog Hospital Safety Score		Aetna POS II		Cigna BP/PAF		Kaiser Oregon		Providence Health Plan POS		Regence BCBS Oregon Preferred		UnitedHealthcare UHC POS/POS	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Saint Alphonsus Medical Center —	N/A													
Saint Alphonsus Medical Center —	N/A													
Ontario, Inc														
Salem Health West Valley Hospital														
Salem Hospital	D													
Samaritan Albany General Hospital														
Samaritan Lebanon Community Hospital														
Samaritan North Lincoln Hospital	N/A													
Samaritan Pacific Community Hospital	N/A													
Santiam Hospital	C													
Shriners Hospital For Children — Portland	N/A													
Sky Lakes Medical Center	C													
Spokane Falls Community Hospital & Health Center	N/A													
St. Charles Bend Campus	C													
St. Charles Medford	N/A													
St. Charles Prineville	N/A													
Walla Walla Memorial Hospital	N/A													
Willamette Valley Medical Center	A													

Percent of Expected:

0-25% Generally unable
Recommend cost-level investigation

26-50% Moderately usable
Recommend additional investigation

51-75% Generally usable
Consider additional investigation

76-100% Highly usable

Northern California — Wide Range of Data Usability

The Northern California regional market shows a broad range of data usability. There are some examples where multiple carriers have comparable data such as the Sutter facilities, but much of the regional market has a relatively low Percent of Expected compared to other regional markets in this analysis. This may indicate that there may be more variability in contracts than in other regional markets (e.g. capitation, custom codes, ICD codes, etc). Blue Shield of California appears to post the most data that meets the highest threshold (>75%) based on the Percent of Expected metric.

Northern California Payer Transparency Data		Leapfrog Hospital Safety Score		Aetna Group POS II		Anthem Anthem PPO		Blue Shield of CA Full PPO		Cigna Cigna OAP		UnitedHealthcare United Group Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Adventist Health and Rideout	B	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Clear Lake	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Feather River	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Howard Memorial	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Lodi Memorial	C	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Mendocino Coast	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Reedley	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Sonoma	A	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health St. Helena	C	●	●	●	●	●	●	●	●	●	●	●	●
Adventist Health Ukiah Valley	A	●	●	●	●	●	●	●	●	●	●	●	●
AHMC Sutter Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Alameda Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Alta Bates Summit Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Alta Bates Summit Medical Center — Alta Bates Campus	B	●	●	●	●	●	●	●	●	●	●	●	●
Banner Lassen Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Barton Memorial Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable (Recommend code-level investigation) ● 26-50% Moderately usable (Recommend additional investigation) ● 51-75% Generally usable (Consider additional investigation) ● 76-100% Highly usable

Northern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Direct POS II		Anthem California		Blue Shield of CA Blue POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
California Pacific Medical Center —	A	●	●	●	●	●	●	●	●	●	●	●	●
California Pacific Medical Center — Mission	A	●	●	●	●	●	●	●	●	●	●	●	●
Bernal Campus & Orthopedic Institute	A	●	●	●	●	●	●	●	●	●	●	●	●
California Pacific Medical Center —	A	●	●	●	●	●	●	●	●	●	●	●	●
Van Ness Campus	A	●	●	●	●	●	●	●	●	●	●	●	●
Chinese Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Clovis Community Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Coalinga Regional Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Collusa Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Community Hospital of the	B	●	●	●	●	●	●	●	●	●	●	●	●
Golden State	B	●	●	●	●	●	●	●	●	●	●	●	●
Community Regional Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Concord Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Dameron Hospital	Not Graded	●	●	●	●	●	●	●	●	●	●	●	●
DePaul Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Medical Center of Stockton	A	●	●	●	●	●	●	●	●	●	●	●	●
Doctors Hospital of Manteca	D	●	●	●	●	●	●	●	●	●	●	●	●
Doctors Medical Center — Modesto	D	●	●	●	●	●	●	●	●	●	●	●	●
Dominican Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Eastern Flumas Hospital — Portola Campus	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Eden Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
El Camino Health — Mountain View Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Emmanuel Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Enloe Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Fairchild Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Fresno Heart & Surgical Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Fresno Surgical Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
George L. Meier Memorial Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Glenn Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Good Samaritan Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

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Northern California Payor Transparency Data		Leapfrog Starburst Survey Score		Aetna Direct POS II		Anthem Preferred		Blue Shield of CA Blue POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare Optima	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Hazel Hawkins Memorial Hospital	N/A												
Hazel Hawkins Memorial Hospital	N/A												
Healdsburg Hospital	N/A												
Highland Hospital	C												
Jerold Phelps Community Hospital	N/A												
John C. Fremont Healthcare District	N/A												
John Muir Health —	C												
Walnut Creek Medical Center	N/A												
Lucile Packard Childrens Hospital Stanford	C												
Mad River Community Hospital	N/A												
Manmoth Hospital	N/A												
MarinHealth Medical Center	B												
Mark Taper Medical Center	N/A												
Marshall Medical Center	A												
Memorial Hospital Los Banos	A												
Memorial Medical Center	B												
Mercy General Hospital	A												
Mercy Hospital of Folsom	B												
Mercy Medical Center	A												
Mercy Medical Center Mt. Shasta	N/A												
Mercy Medical Center Redding	B												
Mercy San Juan Medical Center	A												
Methodist Hospital of Sacramento	A												
Millie Peninsula Medical Center	A												
Modoc Medical Center	N/A												
Napa Surgery Center, LLC	N/A												
Natividad Hospital	A												
Northbay Medical Center	B												

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California Payor Transparency Data		Leapfrog Starburst Survey Score		Aetna Direct POS II		Anthem California PO		Blue Shield of CA Blue POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Northbay Vacaville Hospital	B												
Northern Inyo Hospital	N/A												
Novato Community Hospital	A												
Oak Valley Hospital District	N/A												
O'Connor Hospital	B												
Orchard Hospital	N/A												
Oroville Hospital	D												
Palmer Hospital of Redding	N/A												
Petaluma Valley Hospital	C												
Plumas District Hospital	N/A												
Providence Queen of the Valley Hospital	A												
Providence Redwood Memorial Hospital	N/A												
Providence Santa Rosa Memorial Hospital	B												
Providence St. Joseph Hospital Eureka	B												
Regional Medical Center of San Jose	B												
Saint Agnes Medical Center	C												
Saint Francis Memorial Hospital	B												
Sallinas Valley Health	C												
San Joaquin General Hospital	B												
San Leandro Hospital	C												
San Leandro Hospital	C												
San Ramon Regional Medical Center	C												
Santa Clara Valley Medical Center	C												
Seneca District Hospital	N/A												
Sequoia Hospital	A												
Seron Medical Center Coastside	N/A												
Shasta Regional Medical Center	A												

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California Payor Transparency Data		Leapfrog Survey Score		Aetna POS II		Anthem POS II		Blue Shield of CA		Cigna OAP		UnitedHealthcare UHC POS II	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Shasta Regional Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
Shriners Hospitals for Children — Northern California	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Sierra Nevada Memorial Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
Sonoma Specialty Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Sonoma Valley Hospital	C	○	○	○	○	○	○	○	○	○	○	○	○
Southern Inyo Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
St. Louise Regional Hospital	C	○	○	○	○	○	○	○	○	○	○	○	○
St. Elizabeth Community Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
St. Mary's Medical Center — San Francisco	A	○	○	○	○	○	○	○	○	○	○	○	○
St. Rose Hospital	D	○	○	○	○	○	○	○	○	○	○	○	○
Stanford Health Care	A	○	○	○	○	○	○	○	○	○	○	○	○
Stanford Health Care — Tri-Valley	B	○	○	○	○	○	○	○	○	○	○	○	○
Stanislaus Surgical Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Surprise Valley Community Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Amador Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Auburn Faith Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Coast Hospital	C	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Davis Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Delta Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Lakeside Hospital	B	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Lakeview Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Maiermly & Surgery Center of Santa Cruz	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Medical Center, Sacramento	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Medical Center, Sacramento	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Roseville Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Santa Rosa Regional Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Solano Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Surgical Hospital — North Valley	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Sutter Tracy Community Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California Payor Transparency Data		Leapfrog Survey Score		Aetna POS II		Anthem PPO		Blue Shield of CA		Cigna OAP		UnitedHealthcare POS/POS II	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Tahoe Forest Hospital	N/A	●	○	○	○	○	○	○	○	○	○	○	○
Trinity Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
UCSF Benioff Children's Hospital — Oakland	N/A	○	○	○	○	○	○	○	○	○	○	○	○
UCSF Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
University of California Davis Medical Center	D	○	○	○	○	○	○	○	○	○	○	○	○
Valley Children's Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
Washington Hospital Healthcare System	B	○	○	○	○	○	○	○	○	○	○	○	○
Watsonville Community Hospital	B	○	○	○	○	○	○	○	○	○	○	○	○
Woodland Memorial Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○

Percent of Expected:

● 0-25% Generally unusable
Recommend cost-level investigation

○ 26-50% Moderately usable
Recommend additional investigation

○ 51-75% Generally usable
Consider additional investigation

● 76-100% Highly usable

Southern California — Wide Range of Data Usability

Similar to the observations from the Northern California regional market, Southern California shows a broad range of data usability and Blue Shield of California appears to have the most data that meets the highest threshold (>75%) based on the Percent of Expected metric.

Southern California Payer Transparency Data		Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Full PPO		Cigna Cigna OAP		UnitedHealthcare UHC Choice Plus	
Learning Safety Score	Payer	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
B	Adventist Health Bakersfield	●	●	●	●	●	●	●	●	●	●
B	Adventist Health Delano	●	●	●	●	●	●	●	●	●	●
A	Adventist Health Glendale	●	●	●	●	●	●	●	●	●	●
A	Adventist Health Hanford	●	●	●	●	●	●	●	●	●	●
C	Adventist Health Simi Valley	●	●	●	●	●	●	●	●	●	●
N/A	Adventist Health Tehachapi Valley	●	●	●	●	●	●	●	●	●	●
N/A	Adventist Health Tulare	●	●	●	●	●	●	●	●	●	●
B	Adventist Health White Memorial	●	●	●	●	●	●	●	●	●	●
D	Adventist Health White Memorial Montebello	●	●	●	●	●	●	●	●	●	●
N/A	Adventist Medical Center — Central Valley	●	●	●	●	●	●	●	●	●	●
B	Ahmc Anaheim Regional Medical Center	●	●	●	●	●	●	●	●	●	●
A	Allambra Hospital Medical Center	●	●	●	●	●	●	●	●	●	●
N/A	Alliance Surgery Center Inc.	●	●	●	●	●	●	●	●	●	●
N/A	Anaheim Community Hospital, LLC	●	●	●	●	●	●	●	●	●	●
C	Anaheim Global Medical Center	●	●	●	●	●	●	●	●	●	●
C	Antelope Valley Medical Center	●	●	●	●	●	●	●	●	●	●
B	Arrowhead Regional Medical Center	●	●	●	●	●	●	●	●	●	●
D	Bakersfield Heart Hospital	●	●	●	●	●	●	●	●	●	●
A	Bakersfield Memorial Hospital	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable (Recommend code-level investigation) ● 26-50% Moderately usable (Recommend additional investigation) ● 51-75% Generally usable (Consider additional investigation) ● 76-100% Highly usable

Southern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Direct POS II		Anthem Preferred		Blue Shield of CA SILV PO		Cigna COP		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Barstow Community Hospital	C	●	○	●	○	●	○	●	○	●	○	●	○
Bear Valley Community Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Beverly Hills Doctors Surgery Center	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Casa Colina Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Catalina Island Health	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Cedars-Sinai Marina del Rey Hospital	B	●	○	●	○	●	○	●	○	●	○	●	○
Cedars-Sinai Medical Center	C	●	○	●	○	●	○	●	○	●	○	●	○
Centinela Hospital Medical Center	B	●	○	●	○	●	○	●	○	●	○	●	○
Chapman Global Medical Center	C	●	○	●	○	●	○	●	○	●	○	●	○
Children's Hospital Los Angeles	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Children's Hospital of Orange County	N/A	●	○	●	○	●	○	●	○	●	○	●	○
CHOC at Mission Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○
City of Hope — Helford Clinical Research Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Coast Plaza Hospital	C	●	○	●	○	●	○	●	○	●	○	●	○
Coastal Surgery Center Partner	N/A	●	○	●	○	●	○	●	○	●	○	●	○
College Hospital Costa Mesa	N/A	●	○	●	○	●	○	●	○	●	○	●	○
College Medical Center	D	●	○	●	○	●	○	●	○	●	○	●	○
Colorado River Medical Center	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Community Hospital Long Beach	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Community Hospital of Huntington Park	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Community Hospital of San Bernardino	C	●	○	●	○	●	○	●	○	●	○	●	○
Community Memorial Hospital — Ojai	A	●	○	●	○	●	○	●	○	●	○	●	○
Community Memorial Hospital — Ojai	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Corona Regional Medical Center	A	●	○	●	○	●	○	●	○	●	○	●	○
San Buenaventura	B	●	○	●	○	●	○	●	○	●	○	●	○
Desert Regional Medical Center	B	●	○	●	○	●	○	●	○	●	○	●	○
Desert Valley Hospital	A	●	○	●	○	●	○	●	○	●	○	●	○

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Southern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Direct POS II		Anthem California PO		Blue Shield of CA Blue POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Dignity Health — Covington Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Glendale Memorial Hospital and Health Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Inland Empire Downtown — Bakersfield	B	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Norridge Hospital Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Santa Ana Regional Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — French Hospital Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — DUV Vision ASC	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Docs Surgical Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — East Los Angeles Doctors Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Eisenhower Health	A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — El Centro Regional Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Encanto Health Footbill	B	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Presbyterian Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Emanate Health Inter — Community Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Encino Hospital Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Encino — Tarzana Reg Med Center — Tarzana Campus	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Foothill Regional Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Fountain Valley Regional Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Fountain Valley Regional Hospital & Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Garden Grove Hospital & Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Garfield Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Glendora Oaks Behavioral Health Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Goleta Valley Cottage Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Good Samaritan Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Dignity Health — Greater El Monte Community Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected:

- 0-25% Generally unusable Recommend code-level investigation
- 26-50% Moderately unusable Recommend additional investigation
- 51-75% Generally usable Consider additional investigation
- 76-100% Highly usable

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Southern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Direct POS II		Anthem Preferred		Blue Shield of CA PPO		Cigna OAP		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Healthbridge Children's Hospital — Orange	N/A												
Hennet Global Medical Center	C												
Henry Mayo Newhall Hospital	D												
HI-Desert Medical Center	B												
Hoag Memorial Hospital Presbyterian	A												
Hoag Orthopedic Institute	N/A												
Hollywood Community Hospital at Britman Medical Center	D												
Hollywood Presbyterian Medical Center	A												
Huntington Hospital	C												
Irvine Regional Hospital & Medical Center	N/A												
John F. Kennedy Memorial Hospital	B												
Kaiser Health Medical Center	B												
Kaiser Hospital of USC	A												
Kaiser Permanente District — Kern Valley Hospital	N/A												
L.A. Downtown Medical Center — Downtown Campus	N/A												
Lakewood Regional Medical Center	C												
Loma Linda University Children's Hospital	N/A												
Loma Linda University Medical Center	A												
Loma Linda University Medical Center — Alhambra	A												
Compton Valley Medical Center	B												
Los Alamitos Medical Center	D												
Los Angeles Community Hospital	D												
Los Robles Regional Medical Center	B												
Marian Regional Medical Center	A												
Marion Regional Medical Center — Arroyo Grande	N/A												

Continued on next page

Percent of Expected:

- 0-25% Generally unusable. Recommend code-level investigation.
- 26-50% Moderately usable. Recommend additional investigation.
- 51-75% Generally usable. Consider additional investigation.
- 76-100% Highly usable.

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Southern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Direct POS II		Anthem Preferred		Blue Shield of CA Blue POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare Optima	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Martin Luther King, Jr. Community Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
MD Surgical Solutions, LLC	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Memorial Hospital of Gardena	C	●	●	●	●	●	●	●	●	●	●	●	●
MemorialCare Long Beach Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
MemorialCare Miller Children's & Women's Hospital Long Beach	N/A	●	●	●	●	●	●	●	●	●	●	●	●
MemorialCare Orange Coast Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
MemorialCare Saddleback Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Meriflex Global Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Miraclemile Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Mission Community Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Monterey Park Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Medion Picture & Television Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Mountains Community Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Cable Surgical Center LLC	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Olympia Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Orange County Global Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Pacific Hospital of the Valley	F	●	●	●	●	●	●	●	●	●	●	●	●
Palmdale Regional Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Palo Verde Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Palomar Health Downtown Campus	A	●	●	●	●	●	●	●	●	●	●	●	●
Palomar Medical Center Poway	A	●	●	●	●	●	●	●	●	●	●	●	●
Paradise Valley Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Parview Community Hospital Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
PH Health Downey Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
PH Health Good Samaritan Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
PH Health Whittier Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
Pioneers Memorial Healthcare District	C	●	●	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Southern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Medical POS II		Anthem California		Blue Shield of CA Blue POS		Cigna CIGNA		UnitedHealthcare UnitedHealthcare	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Placentia-Linda Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Pomona Valley Hospital Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Cedars —	C	●	●	●	●	●	●	●	●	●	●	●	●
Sinaloa Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence Holy Cross Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence Little Company of Mary Medical Center San Diego	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence Little Company of Mary Medical Center Torrance	A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Mission Hospital Mission Viejo	A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Saint John's Health Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence Saint Joseph Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Joseph Hospital Orange	C	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Jude Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Mary Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Mary Medical Center — San Diego	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Redlands Community Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Ridgecrest Regional Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Riverside Community Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Ronald Reagan Ucla Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Saint Francis Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
San Antonio Regional Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
San Dimas Community Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
San Gabriel Valley Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
San Geronimo Memorial Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Santa Barbara Cottage Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Santa Monica UCLA Medical Center & Orthopedic Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Santa Ynez Valley Cottage Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Scripps Green Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Southern California Payor Transparency Data		Leapfrog Hospital Safety Score		Aetna Direct POS II		Anthem Preferred		Blue Shield of CA Blue POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Scripps Memorial Hospital Encinitas	A	●	○	●	○	●	○	●	○	●	○	●	○
Scripps Memorial Hospital La Jolla	C	●	○	●	○	●	○	●	○	●	○	●	○
Scripps Mercy Hospital San Diego	A	●	○	●	○	●	○	●	○	●	○	●	○
Sharp Chula Vista Medical Center	B	○	○	○	○	○	○	○	○	○	○	○	○
Sharp Coronado Hospital	B	○	○	○	○	○	○	○	○	○	○	○	○
Sharp Grossmont Hospital	A	○	○	○	○	○	○	○	○	○	○	○	○
Sharp Memorial Hospital	B	○	○	○	○	○	○	○	○	○	○	○	○
Shriners Hospitals for Children	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Sierra View Medical Center	B	○	○	○	○	○	○	○	○	○	○	○	○
Sierra Vista Regional Medical Center	C	○	○	○	○	○	○	○	○	○	○	○	○
South Coast Global Medical Center	C	○	○	○	○	○	○	○	○	○	○	○	○
Southern California Hospital At Hollywood	D	○	○	○	○	○	○	○	○	○	○	○	○
Southwest Healthcare Rancho	B	○	○	○	○	○	○	○	○	○	○	○	○
Springs Hospital	B	○	○	○	○	○	○	○	○	○	○	○	○
St. Bernardine Medical Center	B	○	○	○	○	○	○	○	○	○	○	○	○
St. John's Hospital Camarillo	A	○	○	○	○	○	○	○	○	○	○	○	○
St. Mary Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
Temecula Valley Hospital	B	○	○	○	○	○	○	○	○	○	○	○	○
Tenet Health Central Coast —	D	○	○	○	○	○	○	○	○	○	○	○	○
Twin Cities Community Hospital	N/A	○	○	○	○	○	○	○	○	○	○	○	○
UCLA Medical Center — Sharp	N/A	○	○	○	○	○	○	○	○	○	○	○	○
A Campus of Los Robles	B	○	○	○	○	○	○	○	○	○	○	○	○
Torrance Memorial Medical Center	B	○	○	○	○	○	○	○	○	○	○	○	○
Tri-City Medical Center	C	○	○	○	○	○	○	○	○	○	○	○	○
Tulare Regional Medical Center	N/A	○	○	○	○	○	○	○	○	○	○	○	○
UC San Diego Health East Campus	C	○	○	○	○	○	○	○	○	○	○	○	○
UC San Diego Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
University of California Irvine Medical Center	A	○	○	○	○	○	○	○	○	○	○	○	○
USC Arcadia Hospital	C	○	○	○	○	○	○	○	○	○	○	○	○

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ○ 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Southern California Payor Transparency Data		Leapfrog Survey Score		Aetna POS II		Anthem PPO		Blue Shield of CA		Cigna OAP		UnitedHealthcare UHC POS Opt	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
USC Norris Cancer Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
USC Verdugo Hills Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Valley Presbyterian Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Ventura County Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Victor Valley Global Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Viccella Ambulatory Surgical Center, LLC	N/A	●	●	●	●	●	●	●	●	●	●	●	●
West Covina Medical Center, Inc.	N/A	●	●	●	●	●	●	●	●	●	●	●	●
West Hills Hospital & Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Whittier Hospital Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Phoenix — Generally Highly Usable Data

The data usability is reasonably good for many facilities in this regional market and meets the highest threshold (75%) based on the Percent of Expected metric.

Phoenix Payor Transparency Data	Leapfrog Survey Score	Aetna POS II		BBA AZ BBA AZ		Cigna CAP		UnitedHealthcare UnitedHealthcare	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Abrazo Arrowhead Campus	D	●	●	●	●	●	●	●	●
Abrazo Central Campus	D	●	●	●	●	●	●	●	●
Abrazo Scottsdale Campus	D	●	●	●	●	●	●	●	●
Abrazo West Campus	D	●	●	●	●	●	●	●	●
Arizona Heart Hospital	N/A	●	●	●	●	●	●	●	●
Arizona Spine and Joint Hospital	N/A	●	●	●	●	●	●	●	●
Banner — University Medical Center Phoenix	C	●	●	●	●	●	●	●	●
Banner Baywood Medical Center	B	●	●	●	●	●	●	●	●
Banner Boswell Medical Center	C	●	●	●	●	●	●	●	●
Banner Casa Grande Medical Center	C	●	●	●	●	●	●	●	●
Banner Del E Webb Medical Center	B	●	●	●	●	●	●	●	●
Banner Desert Medical Center	C	●	●	●	●	●	●	●	●
Banner Estrella Medical Center	C	●	●	●	●	●	●	●	●
Banner Gateway Medical Center	C	●	●	●	●	●	●	●	●
Banner Goldfield Medical Center	N/A	●	●	●	●	●	●	●	●
Banner Heart Hospital	N/A	●	●	●	●	●	●	●	●
Banner Ironwood Medical Center	A	●	●	●	●	●	●	●	●
Banner Ocotillo Medical Center	B	●	●	●	●	●	●	●	●
Banner Thunderbird Medical Center	C	●	●	●	●	●	●	●	●
Chandler Regional Medical Center	A	●	●	●	●	●	●	●	●
Dignity Health — Arizona General Hospital, Laween	N/A	●	●	●	●	●	●	●	●
Dignity Health — Arizona General Hospital, Mesa	C	●	●	●	●	●	●	●	●
Dignity Health Arizona Specialty Hospital	N/A	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Phoenix Payor Transparency Data	Leapfrog Hospital Safety Score		Area Average, POS II		DBS/AZ POS/CC		Sign Cigna OAP		UnitedHealthcare UHC Phoenix POS	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Heart and Vascular Surgical Center, LLC	N/A									
Heart Health Center LLC	N/A									
HonorHealth Deer Valley Medical Center	B									
HonorHealth John C. Lincoln Medical Center	B									
HonorHealth Scottsdale Osborn Medical Center	A									
HonorHealth Scottsdale Shea Medical Center	A									
HonorHealth Scottsdale Thompson Peak Medical Center	A									
HonorHealth Sonoran Crossing Medical Center	A									
Hu Hu Kam Memorial Hospital	N/A									
Mayo Clinic Hospital — Phoenix	A									
Mercy Gilbert Medical Center	A									
Mountain Vista Medical Center, LP	A									
Peak Surgery Center of Avondale	N/A									
Phoenix Children's Hospital	N/A									
Ski Ambulatory Surgical Center, LLC	N/A									
Ski Ambulatory Surgical Centers, LLC	N/A									
St. Joseph's Hospital and Medical Center	C									
Tampa St. Luke's Hospital	B									
The Core Institute Specialty Hospital	N/A									
Valleywise Health Medical Center	B									
Western Regional Medical Center	N/A									
Wickenburg Community Hospital	N/A									

Percent of Expected:

- 0-25% Generally unusable
Recommend cost-level investigation
- 26-50% Moderately usable
Recommend additional investigation
- 51-75% Generally usable
Consider additional investigation
- 76-100% Highly usable

Denver — Generally Highly Usable Data

The data usability is strong for Aetna, Anthem, and Cigna (FIP) in this regional market. The Aetna and Anthem data meets the highest threshold (75%) based on the Percent of Expected metric for many facilities, which is not the case in all markets. The UHC FIP data in this market is less usable than others. Similar to other markets, Cigna and UHC have lower data usability for FOP services driven by the use of custom codes and percent of charge information as described earlier in the report.

Anthem notably does not have PPO rates at University of Colorado Hospital Authority, though it is unknown if these two entities have a PPO contract in place. They do, however, have robust results under the Anthem High Performance network that meets our highest threshold (75%) based on the Percent of Expected metric. The Anthem High Performance network is a narrow network product that tends to have lower rates than the Anthem broad networks.

Denver Payer Transparency Data	Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		Cigna Cigna PPO		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
AdventHealth Castle Rock	A	●	●	●	●	●	●	●	●
AdventHealth Littleton	A	●	●	●	●	●	●	●	●
AdventHealth Parker	B	●	●	●	●	●	●	●	●
AdventHealth Porter	A	●	●	●	●	●	●	●	●
Children's Hospital Colorado — Anschutz Medical Campus, Aurora	N/A	●	●	●	●	●	●	●	●
CommonSpirit — St. Anthony Hospital	B	●	●	●	●	●	●	●	●
CommonSpirit — St. Anthony North Hospital	A	●	●	●	●	●	●	●	●
Denver Health Medical Center	B	●	●	●	●	●	●	●	●
Intermountain Health Platte Valley Hospital	A	●	●	●	●	●	●	●	●
Intermountain Health Saint Joseph Hospital	A	●	●	●	●	●	●	●	●
Lutheran Medical Center	A	●	●	●	●	●	●	●	●
National Jewish Health	N/A	●	●	●	●	●	●	●	●
North Suburban Medical Center	C	●	●	●	●	●	●	●	●
OrthoColorado Hospital at St. Anthony Medical Campus	N/A	●	●	●	●	●	●	●	●
Presbyterian St. Luke's Medical Center	C	●	●	●	●	●	●	●	●
Rose Medical Center	A	●	●	●	●	●	●	●	●
SCL Health Community Hospital — Northglenn	N/A	●	●	●	●	●	●	●	●

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Denver		Leapfrog Grade Star Rating		Aurora POS II		Anthem POS II		Cigna POS II		UnitedHealthcare POS II	
Payer Transparency Data		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Sky Ridge Medical Center	C	●	●	●	●	●	●	●	●	●	●
Swedish Medical Center	A	●	●	●	●	●	●	●	●	●	●
The Medical Center of Aurora	C	●	●	●	●	●	●	●	●	●	●
UCHealth Broomfield Hospital	N/A	●	●	●	●	●	●	●	●	●	●
UCHealth Highlands Ranch Hospital	C	●	●	●	●	●	●	●	●	●	●
University of Colorado Hospital Authority	D	●	●	●	●	●	●	●	●	●	●

Percent of Expected:

- 0-25% Generally unusable. Recommend cost-level investigation.
- 26-50% Moderately usable. Recommend additional investigation.
- 51-75% Generally usable. Consider additional investigation.
- 76-100% Highly usable.

Dallas — Mixed Data Usability

The data usability in this regional market is mixed. There is quite a bit of variability across the different payers and health systems. BCBS TX has the strongest usability with many facilities that meet the highest threshold (≥75%) based on the Percent of Expected metric.

Facility	Leapfrog Star Rating		Aetna Chiro. POS II		BCBS TX Blue Choice PPO		Chen Care GAP		UnitedHealthcare UnitedChoice Plan	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Baylor Emergency Medical Center	N/A									
Baylor Scott & White Emergency Hospital — Keller	N/A									
Baylor Scott & White Heart and Vascular Hospital — Dallas	A									
Baylor Scott & White Medical Center — Genternal	A									
Baylor Scott & White Medical Center — Frisco	N/A									
Baylor Scott & White Medical Center — Irving	B									
Baylor Scott & White Medical Center — Lake Pointe	C									
Baylor Scott & White Medical Center — McKinney	N/A									
Baylor Scott & White Medical Center — Plano	A									
Baylor Scott & White Medical Center — Sunnyvale	D									
Baylor Scott & White Medical Center — Trophy Club	A									
Baylor Scott & White Medical Center — Uptown	A									
Baylor Scott & White Medical Center — Waxahachie	A									
Baylor Scott & White Surgical Hospital — Las Colinas	N/A									
Baylor Scott & White The Heart Hospital — Denton	N/A									
Baylor Scott & White The Heart Hospital — Plano	N/A									
Baylor University Medical Center	C									
Carrollton Regional Medical Center	N/A									
Children's Medical Center of Dallas	N/A									
Cook Children's Medical Center Plano	N/A									
Cook Children's Medical Center	N/A									
Cook Children's Medical Center — Prosper	N/A									

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Dallas Payer Transparency Data		Leapfrog Hospital Safety Score	Area Score POS II	QUEST Best Price PPO	Sign Cigna OAP	UnitedHealthcare UHC Choice Plus				
			In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Crescent Medical Center Lancaster	N/A									
Dallas Medical Center	B									
Dallas Regional Medical Center	C									
Ennis Regional Medical Center	N/A									
Hunt Regional Medical Center	C									
LeSant Orthopaedic Hospital — Carrollton	N/A									
Mayhill Hospital	N/A									
Medical City Dallas	A									
Medical City Denton	C									
Medical City Las Colinas	C									
Medical City Lewisville	B									
Medical City McKinney	B									
Medical City Plano	C									
Medical City Sachse	N/A									
Methodist Charlton Medical Center	B									
Methodist Dallas Medical Center	A									
Methodist Hospital For Surgery	N/A									
Methodist McKinney Hospital	N/A									
Methodist Midlothian Medical Center	A									
Methodist Richardson Medical Center	A									
North Central Surgical Center LLP	N/A									
Parkland Health	D									
Scottish Rite Hospital for Children	N/A									
Texas Health Center for Diagnostics & Surgery — Plano	N/A									
Texas Health Hospital Frisco	N/A									
Texas Health Hospital Rockwall	C									
Texas Health Presbyterian Hospital Allen	C									

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately unusable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Dallas Payer Transparency Data		Leapfrog Quality Study Score		Area Score, POS II		SABER Best Practice PPO		Sign CAP		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Texas Health Presbyterian Hospital Dallas	D	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Denton	C	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Flower Mound	C	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Kaufman	B	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Plano	C	●	●	●	●	●	●	●	●	●	●
Texas Institute for Surgery at Texas Health Presbyterian Dallas	N/A	●	●	●	●	●	●	●	●	●	●
UT Southwestern University Hospital	A	●	●	●	●	●	●	●	●	●	●
UT Southwestern University Hospital — Zale Lipshy	A	●	●	●	●	●	●	●	●	●	●
White Rock Medical Center	D	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Chicago — Reasonably Usable Inpatient Data with Mixed Outpatient Data Usability
 Similar to other regional markets, Chicago has reasonably strong FIP data across all four payers. However, the FOP data is mixed with very few facilities that meet the highest threshold (>75%).

Chicago Payer Transparency Data	Leapfrog Hospital Safety Score	Aetna Chicago POS II		BCBS IL Preferred Provider Organizations		Cigna Chicago OAP		UnitedHealthcare United Chicago Point	
		Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Advocate Christ Medical Center	C								
Advocate Good Samaritan Hospital	C								
Advocate Illinois Masonic Medical Center	B								
Advocate Lutheran General Hospital	B								
Advocate South Suburban Hospital	B								
Advocate Trinity Hospital	C								
Ann & Robert H. Lurie Children's Hospital of Chicago	N/A								
Ascension Alexian Brothers Medical Center	C								
Ascension Resurrection	B								
Ascension Saint Alexius	B								
Ascension Saint Francis	A								
Ascension Saint Joseph — Joliet	C								
Ascension Saint Joseph Hospital — Chicago	C								
Ascension Saint Mary — Chicago	B								
Centegra Health System — Woodstock Hospital	N/A								
Community First Medical Center	D								
Edward Hospital	A								
Elmhurst Hospital	A								
Franciscan Health Olympia Fields	C								
Holy Cross Hospital	C								
Humboldt Park Health	C								
Insight Hospital and Medical Center Chicago	N/A								

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Chicago Payor Transparency Data		Leapfrog Grade Score	Area Score	Area POS II	BCBS-IL Participating Providers		Sign CAP		Uncoordinated Care	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Jackson Park Hospital		Not Graded								
John H. Stroger, Jr. Hospital of Cook County		B								
La Rabida Children's Hospital		N/A								
Loretto Hospital		A								
Louis A. Weiss Memorial Hospital		D								
Loyola University Medical Center		B								
Loyola University Medical Center		C								
Mackay Hospital		A								
MercyHealth Hospital and Medical Center — Harvard		N/A								
Morris Hospital & Healthcare Centers		A								
Mount Sinai Hospital		C								
NorthShore University HealthSystem Evanston Hospital		A								
Northwest Community Hospital		A								
Northwestern Medicine Central DuPage Hospital		A								
Northwestern Medicine McHenry Hospital		A								
Northwestern Medicine Palos Hospital		A								
Northwestern Memorial Hospital		A								
Oak Forest Hospital		N/A								
OSF Little Company of Mary Medical Center		B								
Provident Hospital of Cook County		N/A								
Roseland Community Hospital		D								
Rush Oak Park Hospital		B								
Rush University Medical Center		A								
Sacred Heart Hospital		N/A								
Saint Anthony Hospital		C								
Shrires Hospitals For Children		N/A								
Silver Cross Hospital and Medical Centers		A								

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Chicago Payer Transparency Data		Leapfrog Grading Score		Area Score, POS II		BCBS IL Participating Providers		Sign CAP		Uncoordinated Care Risk	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
South Shore Hospital	A	●	●	●	●	●	●	●	●	●	●
Saint Mary's and Elizabeth Medical Center — Claremont Campus	N/A	●	●	●	●	●	●	●	●	●	●
St. Bernard Hospital and Health Care Center	A	●	●	●	●	●	●	●	●	●	●
Swedish Hospital	C	●	●	●	●	●	●	●	●	●	●
The University of Chicago Medical Center	A	●	●	●	●	●	●	●	●	●	●
Thorak Memorial Hospital	C	●	●	●	●	●	●	●	●	●	●
Thorak Memorial Hospital Andersonville	N/A	●	●	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth Bolingbrook	A	●	●	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth Glenoaks	C	●	●	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth Hinsdale	A	●	●	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth La Grange	A	●	●	●	●	●	●	●	●	●	●
UChicago Medicine Ingalls Memorial Hospital	C	●	●	●	●	●	●	●	●	●	●
University of Illinois Hospital and Clinics	C	●	●	●	●	●	●	●	●	●	●
West Suburban Medical Center	D	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Atlanta — Relatively Lower Data Usability with Pockets of Usable Data

The data usability for many facilities in this regional market is lower than some of the other markets such as Seattle, Phoenix, and Denver. However, there are many facilities and health systems that meet the highest threshold (75%) based on the Percent of Expected metric.

Atlanta Payer Transparency Data	Leasing Supply Score	Aetna POS II		Anthem POS		Cigna OAP		UnitedHealthcare UHC Choice Plan	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Atlanta Medical Center — South Campus	N/A								
Children's Healthcare of Atlanta at Eggleston Hospital	N/A								
Children's Healthcare of Atlanta at Scottish Rite Hospital	N/A								
Emory Decatur Hospital	C								
Emory Hilldale Hospital	B								
Emory Saint Joseph's Hospital of Atlanta, Inc.	C								
Emory University Hospital	C								
Emory University Hospital Midtown	C								
Grady Memorial Hospital	N/A								
Higgins General Hospital	N/A								
Jasper Memorial Hospital	N/A								
Midtown Urology/Surgical Center	N/A								
Morgan Medical Center	N/A								
Northwest Atlanta Vascular Care LLC	N/A								
Northwest Georgia Medical Center Barrow	Not Graded								
Northside Hospital	C								
Northside Hospital Cherokee	C								
Northside Hospital Duluth	C								
Northside Hospital Forsyth	C								
Northside Hospital Gwinnett	C								
Northwest Atlanta Vascular Care LLC	N/A								
Piedmont Atlanta Hospital	A								

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Atlanta Payer Transparency Data		Leapfrog Grade Survey Score		Area POS II		Anthem POS		Cigna CAP		UnitedHealthcare UHC POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Atlanta Medical Center – South Campus	N/A										
Piedmont Cartersville Medical Center	B										
Piedmont Eastside Medical Center	B										
Piedmont Fayette Hospital	A										
Piedmont Henry Hospital	A										
Piedmont Mountside Hospital, Inc.	B										
Piedmont Newnan Hospital, Inc	B										
Piedmont Newcon Hospital	A										
Piedmont Rockdale Hospital	B										
Piedmont Walton Hospital, Inc	B										
Southeast Atlanta Vascular Care, LLC	N/A										
Southeastern Regional Medical Center, Inc.	N/A										
Southern Regional Medical Center	C										
Southwest Atlanta Vascular Care	N/A										
Tanner Medical Center – Carrollton	C										
Tanner Medical Center – Villa Rica	A										
Warm Springs Medical Center	N/A										
Wellstar Cobb Medical Center	B										
Wellstar Douglas Medical Center	B										
Wellstar Kennestone Regional Medical Center	B										
Wellstar North Fulton Medical Center	C										
Wellstar Paulding Hospital	A										
Wellstar Spalding Medical Center	B										
Wellstar Sylvan Grove Medical Center	N/A										
Wesley Woods Geriatric Hospital	N/A										

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

New York City/Northern New Jersey — Reasonably Good Inpatient Facility Data

The data usability is reasonably good for many facilities in this regional market and meets the highest threshold (>75%) based on the Percent of Expected metric, especially for FTP services. Horizon BCBS NJ has less credible data, which is expected based on its service area (focused on facilities located in New Jersey versus New York). Since this MSA includes both states, it is included here for comparison purposes.

NYC/Northern New Jersey Payer Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Inpatient PPO		Cigna Direct PDP		EmblemHealth Inpatient/Outpatient		Horizon BCBS NJ Inpatient/Outpatient		UnitedHealthcare United Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Bergen New Bridge Medical Center	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Blytheedale Children's Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○
BronxCare Health System	C	●	○	●	○	●	○	●	○	●	○	●	○
Brookdale Hospital Medical Center	D	●	○	●	○	●	○	●	○	●	○	●	○
Brooklyn Hospital Center — Downtown Campus	B	●	○	●	○	●	○	●	○	●	○	●	○
Bayonne Medical Center	C	●	○	●	○	●	○	●	○	●	○	●	○
CapePoint Health — Christ Hospital	Not Graded	●	○	●	○	●	○	●	○	●	○	●	○
CapePoint Health — Hoboken University Medical Center	C	●	○	●	○	●	○	●	○	●	○	●	○
Community Hospital At Dobbs Ferry	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Englewood Hospital and Medical Center	A	●	○	●	○	●	○	●	○	●	○	●	○
Flushing Hospital Medical Center	C	●	○	●	○	●	○	●	○	●	○	●	○
Forest Hills Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○
Good Samaritan Hospital of Suffern	D	●	○	●	○	●	○	●	○	●	○	●	○
Hackensack Meridian Health	A	●	○	●	○	●	○	●	○	●	○	●	○
Pascack Valley Medical Center	A	●	○	●	○	●	○	●	○	●	○	●	○
Hackensack University Medical Center	A	●	○	●	○	●	○	●	○	●	○	●	○
Helen Hayes Hospital	N/A	●	○	●	○	●	○	●	○	●	○	●	○

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Percent of Expected: ● 0-25% Generally unusable Recurrence code-level investigation ○ 26-50% Moderately usable Recurrence additional investigation ● 51-75% Generally usable Recurrence additional investigation ● 76-100% Highly usable

Hospital Name	Leafrefe Hospital Surgery		Adara Pop II		Auham PPO		Cigna CAP		EmblemHealth (NYNJ) PPO		Horizon BCBS NJ (NYNJ) PPO		UnitedHealthcare (NYNJ) PPO	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Holy Name Medical Center	A													
Hospital For Special Surgery	N/A													
Hudson Regional Hospital	C													
Interfaith Medical Center	N/A													
Jacobi Medical Center	D													
Jamaica Hospital Medical Center	C													
Jersey City Medical Center	B													
King's County Hospital Center	D													
Kingbrook Jewish Medical Center	N/A													
Lenox Hill Hospital	A													
Long Island Jewish Medical Center	A													
Lutheran Medical Center	A													
Maimonides Medical Center	C													
Maimonides Midwood Community Hospital	D													
Memorial Sloan Kettering Cancer Center	N/A													
Montefiore Medical Center	C													
Montefiore Mount Vernon Hospital	N/A													
Montefiore New Rochelle Hospital	C													
Montefiore Nyack Hospital	C													
Mount Sinai Beth Israel	C													
Mount Sinai Hospital	B													
Mount Sinai West	B													
New York Downtown Hospital	N/A													
New York Eye and Ear Infirmary	N/A													
New York Presbyterian Hospital — Weill Cornell Medical Center	A													
New York-Presbyterian Hospital — Lawrence	N/A													

Continued on next page

Percent of Expected: ● 0-25% Generally unable to recommend cost-level investigation ● 26-50% Moderately unable to recommend additional investigation ● 51-75% Generally usable consider additional investigation ● 76-100% Highly usable

NYC/Northern New Jersey Payor Transparency Data		Leapfrog Hospital Safety Score	Adva POS II	Aetna POS	Cigna CAP	EmblemHealth POS	Horizon B2B NJ POS	UnitedHealthcare POS		
			In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
NewYork-Presbyterian Brooklyn	A									
NewYork-Presbyterian Hudson	B									
NewYork-Presbyterian Valley Hospital										
NewYork-Presbyterian — Queens	A									
North Central Bronx Hospital	C									
Northern Westchester Hospital	A									
NYC Health + Hospitals — Elmhurst	C									
NYC Health + Hospitals — Harlem										
NYC Health + Hospitals — Lincoln	C									
NYC Health + Hospitals — Metropolitan	B									
NYC Health + Hospitals — South Brooklyn Health										
NYC Health + Hospitals — Bellevue	C									
NYU Langone Hospitals	A									
Palisades Medical Center	B									
Rheps Hospital	A									
Puram Hospital Center	A									
Queens Hospital Center	A									
Richmond University Medical Center	A									
Saint Joseph's Medical Center	C									
St. John's Episcopal Hospital										
St. John's Shore	D									
St. Joseph's University Medical Center	A									
St. Barnabas Hospital	D									
St. John's Riverside Hospital	C									
St. Mary's General Hospital	A									
Staten Island University Hospital	C									
University Hospital of Brooklyn	C									
Valley Hospital	B									

Continued on next page

Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

NYC/Northern New Jersey Payer Transparency Data	Leapfrog Hospital Safety Score		Aetna POS II		Aetna HMO PPO		Cigna OAP		EmblemHealth NYNJ/PA/VA		Horizon B2B NJ Managed Care		UnitedHealthcare NY/PA/VA/CA	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Westchester Medical Center	●	○	●	○	●	○	●	○	●	○	●	○	●	○
White Plains Hospital Center	●	○	●	○	●	○	●	○	●	○	●	○	●	○
Woodhull Medical & Mental Health Center	●	○	●	○	●	○	●	○	●	○	●	○	●	○
Wyckoff Heights Medical Center	●	○	●	○	●	○	●	○	●	○	●	○	●	○

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ○ 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Appendix 4: Usability of HPT Files by Regional Market

A high-level summary of data usability by hospital for the HPT data submitted by hospitals based on the Percent of Expected metric is summarized below. Please note these tables only reflect facility inpatient and facility outpatient data. As noted in the previous appendix, there was far more variation in the usability of negotiated facility rates than professional fees within the MRFs, so figures corresponding to this section focus on the former.

Seattle/Puget Sound's tables are used in the body of the report as examples and are not included again in the appendix. All hospital (HPT) data used for this analysis reflected the most recent available data as of May 1, 2025. Since HPT data is only required to be updated once per year, hospitals are updating their files on a varied cadence across the country. The posted price transparency data is being updated continuously, and it is possible that some of the figures in this report will not match more recently posted information.

Each of the tables also includes the Leapfrog Hospital Safety Grade as of Spring 2025. The Leapfrog Hospital Safety Grade Program grades hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. For more information visit www.hospital.safteygrade.org.

* The Leapfrog Group data used in this display undergoes rigorous verification and quality control processes (see the Leapfrog Hospital Survey, Leapfrog ASC Survey, and the Hospital Safety Grade) and stands behind its methodology. However, as with any data source, the Leapfrog Group cannot warrant or endorse the methodology used by users, end users, and/or third party vendors incorporating Leapfrog data in their own displays. Therefore, Leapfrog does not warrant or endorse the accuracy, reliability, completeness, timeliness or availability of any data in this display and therefore shall not be held liable for any losses or damages caused by reliance on this display.

Oregon — Limited Data Usability

Similar to the TIC data in this regional market, the data usability at a number of health systems is limited. For example, the Providence and Legacy facilities did not post a single negotiated rate or negotiated percentage for any codes for the payers included in this analysis. Instead, they populated the estimated allowed and minimum/maximum standard charge fields and included comments similar to some hospitals in the Atlanta market (summarized in Appendix 2).

Hospital	Legacy		Asante		Cigna		Mach		Providence		Regence		UHC	
	In-patient	Out-patient												
Leapfrog Hospital Safety Score														
Adventist Health Portland	C													
AdventistHealth Tillamook	N/A													
Asante Ashland Community Hospital	N/A													
Asante Rogue Regional Medical Center	C													
Asante Ashland Community Hospital	A													
Asante Rogue Regional Medical Center	D													
Blue Mountain Hospital	N/A													
CHI St. Anthony Hospital	N/A													
Columbia Memorial Hospital	F													
Coquille Valley Hospital	N/A													
Curry General Hospital	N/A													
Good Samaritan Regional Medical Center	N/A													
Good Shepherd Health Care System	C													
Grande Ronde Hospital	N/A													
Harnsey District Hospital	N/A													
Hillisboro Medical Center	N/A													
Lake District Hospital	D													
N/A	N/A													

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Percent of Expected: ● 0-25% Generally unusable Recurrence code-level investigation ● 26-50% Moderately usable Recurrence additional investigation ● 51-75% Generally usable Recurrence additional investigation ● 76-100% Highly usable

Oregon Hospital Transparency Data	Learning Hospital Priority Score	Acme Care POS II		Cigna Light OAP		Moda Continuous		Providence Health Plan Choice		Regence BCBS Regional Preferred		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Legacy Emanuel Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Good Samaritan Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Meridian Park Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Mount Hood Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Salmon Creek Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Legacy Silverton Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Lower Ungava Hospital District	N/A	●	●	●	●	●	●	●	●	●	●	●	●
McKenzie—Willamette Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Mercy Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Mid-Columbia Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Ohio Hospital and Clinics	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Peace Harbor Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth — Sacred Heart Medical Center University District	N/A	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth — St. George's Grove Community Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth Sacred Heart Medical Center at RiverBend	N/A	●	●	●	●	●	●	●	●	●	●	●	●
PeaceHealth Southwest Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Pioneer Memorial Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Hood River	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Milwaukie	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Medford Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence Milwaukie Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Providence Newberg Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Providence Portland Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Seaside Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Mary Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Providence St. Vincent Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Providence Willamette Falls Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●

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Percent of Expected: ● 0-25% Generally unable to recommend cost-level investigation ● 26-50% Moderately unable to recommend additional investigation ● 51-75% Generally usable consider additional investigation ● 76-100% Highly usable

Oregon Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Cigna High DAP		Moda Community		Providence Health Plan Choice		Regence BCBS Regions Preferred		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Saint Alphonsus Medical Center — St. Vincent	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Saint Alphonsus Medical Center — Ontario, Inc	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Salem Health West Valley Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Salem Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
Samaritan Albany General Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
Samaritan Lebanon Community Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Samaritan North Lincoln Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Samaritan Pacific Community Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Santiam Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Shriners Hospital For Children — Portland	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Sky Lakes Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Spokane Falls Hospital & Health Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
St. Charles Bend Campus	C	●	●	●	●	●	●	●	●	●	●	●	●
St. Charles Madras	N/A	●	●	●	●	●	●	●	●	●	●	●	●
St. Charles Prineville	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Walla Walla Memorial Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Willamette Valley Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unable to recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California — Wide Range of Data Usability

The Northern California regional market shows a broad range of data usability. There are some examples where multiple carriers posted comparable data such as for the Sutter facilities, but there is relatively low data usability in this regional market compared to other regional markets in this analysis. This may indicate that there is more variability in contracts than other regional markets (e.g., capitation, custom codes, ICD codes, etc.). Blue Shield of California appears to post the most data that meets the highest threshold (>75%) based on the Percent of Expected metric.

Northern California Hospital Transparency Data		Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Full PPO		Cigna Origin CAP		UnitedHealthcare United Choice Plus	
Hospital	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Full PPO		Cigna Origin CAP		UnitedHealthcare United Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Adventist Health and Ridout	B	●	●	●	●	●	●	●	●	●	●
Adventist Health Clear Lake	N/A	○	○	○	○	○	○	○	○	○	○
Adventist Health Feather River	N/A	○	○	○	○	○	○	○	○	○	○
Adventist Health Howard Memorial	N/A	○	○	○	○	○	○	○	○	○	○
Adventist Health Lodi Memorial	C	○	○	○	○	○	○	○	○	○	○
Adventist Health Mendocino Coast	N/A	○	○	○	○	○	○	○	○	○	○
Adventist Health Reddley	N/A	○	○	○	○	○	○	○	○	○	○
Adventist Health Sonoma	A	○	○	○	○	○	○	○	○	○	○
Adventist Health St. Helena	C	○	○	○	○	○	○	○	○	○	○
Adventist Health Ukiah Valley	A	○	○	○	○	○	○	○	○	○	○
AHMC Sutter Medical Center	B	●	●	●	●	●	●	●	●	●	●
Alameda Hospital	B	○	○	○	○	○	○	○	○	○	○
Alta Bates Summit Medical Center	A	○	○	○	○	○	○	○	○	○	○
Alta Bates Summit Medical Center — Alta Bates Campus	B	○	○	○	○	○	○	○	○	○	○
Banner Lassen Medical Center	N/A	○	○	○	○	○	○	○	○	○	○
Barton Memorial Hospital	B	○	○	○	○	○	○	○	○	○	○

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Percent of Expected: ● 0-25% Generally unusable Recommendation: code-level investigation ○ 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Hospital	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		The Shield of CA PPO		Signa Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
California Pacific Medical Center — California Pacific	A	●	●	●	●	●	●	●	●	●	●
California Pacific Medical Center — Mission Bernal Campus & Orthopedic Institute	A	●	●	●	●	●	●	●	●	●	●
California Pacific Medical Center — San Jose Campus	A	●	●	●	●	●	●	●	●	●	●
Chinese Hospital	C	●	●	●	●	●	●	●	●	●	●
Clovis Community Medical Center	C	●	●	●	●	●	●	●	●	●	●
Coalinga Regional Medical Center	N/A	●	●	●	●	●	●	●	●	●	●
Colusa Medical Center	N/A	●	●	●	●	●	●	●	●	●	●
Community Hospital of the Monterey Peninsula	B	●	●	●	●	●	●	●	●	●	●
Community Regional Medical Center	C	●	●	●	●	●	●	●	●	●	●
Concord Medical Center	C	●	●	●	●	●	●	●	●	●	●
Danaher Hospital	Not Graded	●	●	●	●	●	●	●	●	●	●
DePaul University Health Services Medical Center of Stockton	A	●	●	●	●	●	●	●	●	●	●
Doctors Hospital of Maricopa	D	●	●	●	●	●	●	●	●	●	●
Doctors Medical Center — Modesto	D	●	●	●	●	●	●	●	●	●	●
Dominican Hospital	A	●	●	●	●	●	●	●	●	●	●
Eastern Flumas Hospital — Portola Campus	N/A	●	●	●	●	●	●	●	●	●	●
Eden Medical Center	A	●	●	●	●	●	●	●	●	●	●
El Camino Health — Mountain View Hospital	A	●	●	●	●	●	●	●	●	●	●
Emanuel Medical Center	C	●	●	●	●	●	●	●	●	●	●
Enlow Medical Center	A	●	●	●	●	●	●	●	●	●	●
Fairchild Medical Center	N/A	●	●	●	●	●	●	●	●	●	●
Fresno Heart & Surgical Hospital	N/A	●	●	●	●	●	●	●	●	●	●
Fresno Surgical Hospital	N/A	●	●	●	●	●	●	●	●	●	●
George L. Mea Memorial Hospital	N/A	●	●	●	●	●	●	●	●	●	●
Glenn Medical Center	N/A	●	●	●	●	●	●	●	●	●	●
Good Samaritan Hospital	C	●	●	●	●	●	●	●	●	●	●

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California Hospital Transparency Data	Leapfrog Hospital Safety Score	Kaiser Choice POS II		Anthem Anthem PPO		The Shield of CA PPO		Signa Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Hazel Hawkins Memorial Hospital	N/A										
Hazel Hawkins Memorial Hospital	N/A										
Headlands Hospital	N/A										
Highland Hospital	C										
Jerold Phelps Community Hospital	N/A										
John C. Fremont Healthcare District	N/A										
John Muir Health	C										
Lucile Packard Children's Hospital Stanford	N/A										
Mid River Community Hospital	C										
Mammoth Hospital	N/A										
MarinHealth Medical Center	B										
Marx Tavel Medical Center	N/A										
Menlo Medical Center	A										
Memorial Hospital Los Banos	A										
Memorial Medical Center	B										
Mercy General Hospital	A										
Mercy Hospital of Folsom	A										
Mercy Medical Center	A										
Mercy Medical Center Mt. Shasta	N/A										
Mercy Medical Center Redding	B										
Mercy San Juan Medical Center	A										
Methodist Hospital of Sacramento	A										
Mills-Penninsula Medical Center	A										
Modoc Medical Center	N/A										
Napa Surgery Center, LLC	N/A										
Natividad Hospital	A										
Northbay Medical Center	B										

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California Hospital Transparency Data		Kaiser Permanente POS II		Anthem Admin PPO		The Shield of CA PPO		Signa Cigna OAP		UnitedHealthcare UHC Choice POS	
Hospital	Leapfrog Hospital Safety Score	Kaiser Permanente POS II		Anthem Admin PPO		The Shield of CA PPO		Signa Cigna OAP		UnitedHealthcare UHC Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Northbay/Vacaville Hospital	B										
Northern Inyo Hospital	N/A										
Novato Community Hospital	A										
Oak Valley Hospital District	N/A										
O'Connor Hospital	B										
Orchard Hospital	N/A										
Orville Hospital	D										
Patente Hospital of Redding	N/A										
Petaluma Valley Hospital	C										
Plumas District Hospital	N/A										
Providence Queen of the Valley Medical Center	A										
Providence Redwood Memorial Hospital	N/A										
Providence Santa Rosa Memorial Hospital	B										
Providence St. Joseph Hospital, Eureka	B										
Regional Medical Center of San Jose	B										
Saint Agnes Medical Center	C										
Saltinas Valley Health	B										
San Joaquin General Hospital	B										
San Leandro Hospital	C										
San Leandro Hospital	C										
San Ramon Regional Medical Center	C										
Santa Clara Valley Medical Center	N/A										
Serrita District Hospital	N/A										
Sequoia Hospital	A										
Solon Medical Center Coastside	N/A										
Shasta Regional Medical Center	A										

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Percent of Expected:

- 0-25% Generally unusable. Recommend cost-level investigation.
- 26-50% Moderately usable. Recommend additional investigation.
- 51-75% Generally usable. Consider additional investigation.
- 76-100% Highly usable.

Hospital	Leapfrog Hospital Safety Score	Kaiser Choice POS II		Anthem Anthem PPO		The Shield of CA PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Shasta Regional Medical Center	A	●	○	●	○	●	○	●	○	●	○
Shriners Hospitals for Children — Northern California	N/A	●	○	●	○	●	○	●	○	●	○
Sierra Nevada Memorial Hospital	A	●	○	●	○	●	○	●	○	●	○
Sonoma Specialty Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Sonoma Valley Hospital	C	●	○	●	○	●	○	●	○	●	○
Southern Inyo Hospital	N/A	●	○	●	○	●	○	●	○	●	○
St. Louise Regional Hospital	C	●	○	●	○	●	○	●	○	●	○
St. Elizabeth Community Hospital	A	●	○	●	○	●	○	●	○	●	○
St. Mary's Medical Center — San Francisco	D	●	○	●	○	●	○	●	○	●	○
St. Rose Hospital	D	●	○	●	○	●	○	●	○	●	○
Stanford Health Care	A	●	○	●	○	●	○	●	○	●	○
Stanford Health Care — Tri-Valley	B	●	○	●	○	●	○	●	○	●	○
Stanislaus Surgical Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Surprise Valley Community Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Sutter Amador Faith Hospital	A	●	○	●	○	●	○	●	○	●	○
Sutter Auburn Faith Hospital	A	●	○	●	○	●	○	●	○	●	○
Sutter Coast Hospital	A	●	○	●	○	●	○	●	○	●	○
Sutter Davis Hospital	C	●	○	●	○	●	○	●	○	●	○
Sutter Delta Medical Center	A	●	○	●	○	●	○	●	○	●	○
Sutter Lakeside Hospital	B	●	○	●	○	●	○	●	○	●	○
Sutter Maternity & Surgery Center of Santa Cruz	N/A	●	○	●	○	●	○	●	○	●	○
Sutter Medical Center, Sacramento	A	●	○	●	○	●	○	●	○	●	○
Sutter Roseville Medical Center	A	●	○	●	○	●	○	●	○	●	○
Sutter Santa Rosa Regional Hospital	A	●	○	●	○	●	○	●	○	●	○
Sutter Solano Medical Center	A	●	○	●	○	●	○	●	○	●	○
Sutter Surgical Hospital — North Valley	N/A	●	○	●	○	●	○	●	○	●	○
Sutter Tracy Community Hospital	A	●	○	●	○	●	○	●	○	●	○

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ○ 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Northern California Hospital Transparency Data		Aetna Choice POS II		Anthem Anthem PPO		The Shield of CA PPO PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
Hospital	Leapfrog Hospital Safety Score	In-patient		Out-patient		In-patient		In-patient		In-patient	
		●	○	●	○	●	○	●	○	●	○
Tahoe Forest Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Trinity Hospital	N/A	●	○	●	○	●	○	●	○	●	○
UCSF Benioff Children's Hospital — Oakland	N/A	●	○	●	○	●	○	●	○	●	○
UCSF Medical Center	A	●	○	●	○	●	○	●	○	●	○
University of California Davis Medical Center	D	●	○	●	○	●	○	●	○	●	○
Valley Children's Hospital	N/A	●	○	●	○	●	○	●	○	●	○
Washington Hospital Healthcare System	B	○	●	○	●	○	●	○	●	○	●
Watsonville Community Hospital	B	○	●	○	●	○	●	○	●	○	●
Woodland Memorial Hospital	A	●	○	●	○	●	○	●	○	●	○

Percent of Expected:

- 0-25% Generally unusable
Recommend cost-level investigation
- 26-50% Moderately usable
Recommend additional investigation
- 51-75% Generally usable
Consider additional investigation
- 76-100% Highly usable

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Southern California — Wide Range of Data Usability

Similar to the observations from the Northern California regional market, Southern California shows a broad range of data usability, and Blue Shield of California appears to have the posted data that meets the highest threshold (75%) based on the Percent of Expected metric.

Southern California Hospital Transparency Data		Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Full PPO		Cigna Cigna OAP		UnitedHealthcare UHC Choice Plus	
Leapfrog Safety Score	Hospital	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
		B	Adventist Health Bakersfield	●	●	●	●	●	●	●	●
B	Adventist Health Delano	●	●	●	●	●	●	●	●	●	●
A	Adventist Health Glendale	●	●	●	●	●	●	●	●	●	●
A	Adventist Health Hanford	●	●	●	●	●	●	●	●	●	●
C	Adventist Health Shimi Valley	●	●	●	●	●	●	●	●	●	●
N/A	Adventist Health Tehachapi Valley	●	●	●	●	●	●	●	●	●	●
N/A	Adventist Health Tulare	●	●	●	●	●	●	●	●	●	●
B	Adventist Health White Memorial	●	●	●	●	●	●	●	●	●	●
D	Adventist Health White Memorial Montebello	●	●	●	●	●	●	●	●	●	●
N/A	Adventist Medical Center — Central Valley	●	●	●	●	●	●	●	●	●	●
B	Aflac Anahiem Regional Medical Center	●	●	●	●	●	●	●	●	●	●
A	Allambra Hospital Medical Center	●	●	●	●	●	●	●	●	●	●
N/A	Alliance Surgery Center Inc.	●	●	●	●	●	●	●	●	●	●
N/A	Anahiem Community Hospital, LLC	●	●	●	●	●	●	●	●	●	●
C	Anahiem Global Medical Center	●	●	●	●	●	●	●	●	●	●
C	Antelope Valley Medical Center	●	●	●	●	●	●	●	●	●	●
B	Arrowhead Regional Medical Center	●	●	●	●	●	●	●	●	●	●
D	Bakersfield Heart Hospital	●	●	●	●	●	●	●	●	●	●
A	Bakersfield Memorial Hospital	●	●	●	●	●	●	●	●	●	●

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Percent of Expected: ● 0-25% Generally unusable (Recommend code-level investigation) ● 26-50% Moderately usable (Recommend additional investigation) ● 51-75% Generally usable (Consider additional investigation) ● 76-100% Highly usable

Southern California Hospital Transparency Data	Leapfrog Hospital Safety Score		Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Blue Shield PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Bartlow Community Hospital												
Bean Valley Community Hospital												
Beverly Hills Doctors Surgery Center												
Casa Colina Hospital												
Catalina Island Health												
Cedars-Sinai Marina del Rey Hospital												
Cedars-Sinai Medical Center												
Centina Hospital Medical Center												
Chapman Global Medical Center												
Children's Hospital Los Angeles												
Children's Hospital of Orange County												
CHOC at Mission Hospital												
City of Hope — Helford Clinical Research Hospital												
Coast Palza Hospital												
Coastal Surgery Center Partner												
College Hospital Costa Mesa												
College Medical Center												
Colorado River Medical Center												
Community Hospital Long Beach												
Community Hospital of Huntington Park												
Community Hospital of San Bernardino												
Community Memorial Hospital — Ojai												
Community Memorial Hospital — Ojai												
San Buenaventura												
Corona Regional Medical Center												
Desert Regional Medical Center												
Desert Valley Hospital												

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Southern California Hospital Transparency Data	Leapfrog Hospital Safety Score		Kaiser Choice POS II		Anthem Anthem PPO		Blue Shield of CA Blue Shield PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Dignity Health — Cerritos Regional Medical Center												
Dignity Health — Glendale Memorial Hospital and Health Center												
Dignity Health — Long Beach Downtown — Bakersfield												
Dignity Health — Northridge Hospital Medical Center												
Dignity Health — Santa Ana Regional Medical Center												
Dignity Health — French Hospital Medical Center												
DLV Vision ASC												
Docu Surgical Hospital												
N/A												
N/A												
East Los Angeles Doctors Hospital												
Eleanor Health												
El Centro Regional Medical Center												
Emery Health Esophill												
Presbyterian Hospital												
Emery Health Inter — Community Hospital												
Encho Hospital Medical Center												
Encho — Tarzana Reg Med Center — Tarzana Campus												
N/A												
N/A												
Foothill Regional Medical Center												
Fountain Valley Regional Hospital & Medical Center												
C												
Grady Grove Hospital & Medical Center												
B												
Garfield Medical Center												
Glendora Oaks Behavioral Health Hospital												
N/A												
Goleta Valley Cottage Hospital												
A												
Good Samaritan Hospital												
N/A												
Greater El Monte Community Hospital												
A												

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Southern California Hospital Transparency Data	Leapfrog Hospital Safety Score	Kaiser Choice POS II		Anthem Anthem PPO		The Shield of CA PPO PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
HealthBridge Children's Hospital — Orange	N/A	●	●	●	●	●	●	●	●	●	●
Hennet Global Medical Center	C	●	●	●	●	●	●	●	●	●	●
Henry Mayo Newhall Hospital	D	●	●	●	●	●	●	●	●	●	●
HI-Desert Medical Center	B	●	●	●	●	●	●	●	●	●	●
Hoag Memorial Hospital Presbyterian	A	●	●	●	●	●	●	●	●	●	●
Hoag Orthopedic Institute	N/A	●	●	●	●	●	●	●	●	●	●
Hollywood Community Hospital at Brotman Medical Center	D	●	●	●	●	●	●	●	●	●	●
Hollywood Presbyterian Medical Center	A	●	●	●	●	●	●	●	●	●	●
Huntington Hospital	C	●	●	●	●	●	●	●	●	●	●
Irvine Regional Hospital & Medical Center	N/A	●	●	●	●	●	●	●	●	●	●
John F. Kennedy Memorial Hospital	B	●	●	●	●	●	●	●	●	●	●
Kaweah Health Medical Center	B	●	●	●	●	●	●	●	●	●	●
Keesa Hospital of Los Angeles	A	●	●	●	●	●	●	●	●	●	●
Kern Valley Hospital	N/A	●	●	●	●	●	●	●	●	●	●
L.A. Downtown Medical Center — Downtown Campus	N/A	●	●	●	●	●	●	●	●	●	●
Lakewood Regional Medical Center	C	●	●	●	●	●	●	●	●	●	●
Loma Linda University Children's Hospital	N/A	●	●	●	●	●	●	●	●	●	●
Loma Linda University Medical Center	A	●	●	●	●	●	●	●	●	●	●
Loma Linda University Medical Center — Midvale	A	●	●	●	●	●	●	●	●	●	●
Lompoc Valley Medical Center	B	●	●	●	●	●	●	●	●	●	●
Los Alamitos Medical Center	D	●	●	●	●	●	●	●	●	●	●
Los Angeles Community Hospital	D	●	●	●	●	●	●	●	●	●	●
Los Robles Regional Medical Center	B	●	●	●	●	●	●	●	●	●	●
Marian Regional Medical Center	A	●	●	●	●	●	●	●	●	●	●
Marian Regional Medical Center — Arcyos Grande	N/A	●	●	●	●	●	●	●	●	●	●

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Percent of Expected:

- 0-25% Generally unusable
Recommend cost-level investigation
- 26-50% Moderately usable
Recommend additional investigation
- 51-75% Generally usable
Consider additional investigation
- 76-100% Highly usable

Leveraging Health Care Price Transparency | Page 95 of 105

Southern California Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		Blue Shield of CA Blue Shield PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Palestina-Linda Hospital	B	●	○	●	○	●	○	●	○	●	○
Pomona Valley Hospital Medical Center	A	○	○	○	○	○	○	○	○	○	○
Providence Cedars	C	●	○	●	○	●	○	●	○	●	○
Sinal Terzana Medical Center	B	●	○	●	○	●	○	●	○	●	○
Providence Holy Cross Medical Center	B	●	○	●	○	●	○	●	○	●	○
Providence Little Company of Mary Medical Center San Bruno	B	●	○	●	○	●	○	●	○	●	○
Providence Little Company of Mary Medical Center Torrance	A	○	○	○	○	○	○	○	○	○	○
Providence Mission Hospital Mission Viejo	A	○	○	○	○	○	○	○	○	○	○
Providence Saint John's Health Center	B	●	○	●	○	●	○	●	○	●	○
Providence Saint Joseph Medical Center	B	●	○	●	○	●	○	●	○	●	○
Providence St. Joseph Hospital Orange	C	●	○	●	○	●	○	●	○	●	○
Providence St. Jude Medical Center	A	○	○	○	○	○	○	○	○	○	○
Providence St. Mary Medical Center	C	●	○	●	○	●	○	●	○	●	○
Rady Children's Hospital - San Diego	N/A	○	○	○	○	○	○	○	○	○	○
Redlands Community Hospital	C	○	○	○	○	○	○	○	○	○	○
Ridgecrest Regional Hospital	B	○	○	○	○	○	○	○	○	○	○
Riverside Community Hospital	N/A	○	○	○	○	○	○	○	○	○	○
Ronald Reagan Ucla Medical Center	A	○	○	○	○	○	○	○	○	○	○
Saint Francis Medical Center	A	○	○	○	○	○	○	○	○	○	○
San Antonio Regional Hospital	C	●	○	●	○	●	○	●	○	●	○
San Dimas Community Hospital	A	○	○	○	○	○	○	○	○	○	○
San Gabriel Valley Medical Center	C	●	○	●	○	●	○	●	○	●	○
San Geronimo Memorial Hospital	B	○	○	○	○	○	○	○	○	○	○
Santa Barbara Cottage Hospital	A	○	○	○	○	○	○	○	○	○	○
Santa Monica UCLA Medical Center & Orthopaedic Hospital	C	●	○	●	○	●	○	●	○	●	○
Santa Ynez Valley Cottage Hospital	N/A	○	○	○	○	○	○	○	○	○	○
Scripps Green Hospital	A	○	○	○	○	○	○	○	○	○	○

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Percent of Expected:

- 0-25% Generally unusable Recommend code-level investigation
- 26-50% Moderately usable Recommend additional investigation
- 51-75% Generally usable Consider additional investigation
- 76-100% Highly usable

Leveraging Health Care Price Transparency | Page 97 of 185

Southern California Hospital Transparency Data	Leapfrog Hospital Safety Score	Kaiser Choice POS II		Anthem Anthem PPO		Blue Shield of CA Blue Shield PPO		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Scripps Memorial Hospital Encinitas	A										
Scripps Memorial Hospital La Jolla	C										
Scripps Mercy Hospital San Diego	A										
Sharp Chula Vista Medical Center	B										
Sharp Coronado Hospital	B										
Sharp Grossmont Hospital	A										
Sharp Memorial Hospital	B										
Shriners Hospitals For Children	N/A										
Sierra View Medical Center	B										
Sierra Vista Regional Medical Center	C										
South Coast Global Medical Center	C										
Southern California Hospital At Hollywood	D										
Southwest Healthcare Rancho	B										
Springs Hospital	B										
St. Bernardine Medical Center	B										
St. John's Hospital Camarillo	A										
St. Mary Medical Center	A										
Temecula Valley Hospital	B										
Tenet Health Central Coast — Twin Cities Community Hospital, A Campus of Los Robles Hosp.	N/A										
Torrance Memorial Medical Center	B										
Tri-City Medical Center	C										
Tulare Regional Medical Center	N/A										
UC San Diego Health East Campus Medical Center	C										
UC San Diego Medical Center	A										
University of California Irvine Medical Center	A										
USC Arcadia Hospital	C										

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Percent of Expected: ● 0-25% Generally unusable Recommend code-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Southern California Hospital Transparency Data		Kaiser Permanente POS II		Anthem PPO		The Shield of CA PPO		Cigna OAP		UnitedHealthcare UHC Choice Plus	
Leapfrog Hospital Safety Score	Hospital	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
		N/A	USC Norris Cancer Hospital	●	●	●	●	●	●	●	●
B	USC Verdugo Hills Hospital	●	●	●	●	●	●	●	●	●	●
B	valley Presbyterian Hospital	●	●	●	●	●	●	●	●	●	●
C	Ventura County Medical Center	●	●	●	●	●	●	●	●	●	●
C	Victor Valley Global Medical Center	●	●	●	●	●	●	●	●	●	●
N/A	Vista Ambulatory Surgical Center, LLC	●	●	●	●	●	●	●	●	●	●
N/A	West Covina Medical Center, Inc.	●	●	●	●	●	●	●	●	●	●
D	West Hills Hospital & Medical Center	●	●	●	●	●	●	●	●	●	●
A	Whittier Hospital Medical Center	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Phoenix — Relatively More Robust Data Usability

The HPT data in Phoenix appears to be more robust than other regional markets as rates were able to be identified for most large facilities, and majority have Percent of Expected above 75% for FIP and above 50% for FOP.

Phoenix Hospital Transparency Data	Leapfrog Hospital Safety Score	Acho CHS-CO II		BBS AZ BBS AZ		Cigna CIGNA_OAP		Unishield/Stone UMC/Stone Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Abrazo Arrowhead Campus	D								
Abrazo Central Campus	D								
Abrazo Scottsdale Campus	D								
Abrazo West Campus	D								
Arizona Heart Hospital	N/A								
Arizona Spine and Joint Hospital	N/A								
Banner — University Medical Center Phoenix	C								
Banner Baywood Medical Center	B								
Banner Boswell Medical Center	C								
Banner Casa Grande Medical Center	C								
Banner Deer E Webb Medical Center	B								
Banner Desert Medical Center	C								
Banner Estrella Medical Center	C								
Banner Gateway Medical Center	C								
Banner Heart Hospital	N/A								
Banner Goldfield Medical Center	N/A								
Banner Ironwood Medical Center	A								
Banner Ocotillo Medical Center	B								
Banner Thunderbird Medical Center	C								
Chandler Regional Medical Center	A								
Dignity Health — Arizona General Hospital Laveen	N/A								
Dignity Health — Arizona General Hospital Mesa	C								

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Phoenix Hospital Transparency Data	Leapfrog Hospital Safety Score	Avera Choice POS II		Kaiser Permanente POS AZ		Cigna Cigna OAP		UnitedHealthcare UHC Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Dignity Health Arizona Specialty Hospital	N/A	●	○	●	○	●	○	●	○
Heart and Vascular Surgical Center, LLC	N/A	●	○	●	○	●	○	●	○
Heart Health Center, LLC	N/A	●	○	●	○	●	○	●	○
HonorHealth Deer Valley Medical Center	B	●	○	●	○	●	○	●	○
HonorHealth John C. Lincoln Medical Center	B	●	○	●	○	●	○	●	○
HonorHealth Scottsdale Osborn Medical Center	A	●	○	●	○	●	○	●	○
HonorHealth Scottsdale Shea Medical Center	A	●	○	●	○	●	○	●	○
HonorHealth Scottsdale Thompson Peak Medical Center	A	●	○	●	○	●	○	●	○
HonorHealth Sonoran Crossing Medical Center	A	●	○	●	○	●	○	●	○
Hu Hu Kam Memorial Hospital	N/A	●	○	●	○	●	○	●	○
Mayo Clinic Hospital — Phoenix	A	●	○	●	○	●	○	●	○
Mercy Gilbert Medical Center	A	●	○	●	○	●	○	●	○
Mountain Vista Medical Center, LP	A	●	○	●	○	●	○	●	○
Peak Surgery Center of Avondale	N/A	●	○	●	○	●	○	●	○
Phoenix Children's Hospital	N/A	●	○	●	○	●	○	●	○
Phoenix Children's Hospital	N/A	●	○	●	○	●	○	●	○
Ski Ambulatory Surgical Center, LLC	N/A	●	○	●	○	●	○	●	○
Ski Ambulatory Surgical Centers, LLC	N/A	●	○	●	○	●	○	●	○
St. Joseph's Hospital and Medical Center	C	●	○	●	○	●	○	●	○
Tempe St. Luke's Hospital	B	●	○	●	○	●	○	●	○
The Core Institute Specialty Hospital	N/A	●	○	●	○	●	○	●	○
Valleywise Health Medical Center	B	●	○	●	○	●	○	●	○
Western Regional Medical Center	N/A	●	○	●	○	●	○	●	○
Wickenburg Community Hospital	N/A	●	○	●	○	●	○	●	○

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ○ 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Denver — Greater Data Usability

The HPT data in this region appears to have far more usable data than many other regional markets included in this analysis, particularly for FIP. Very few facilities have our lowest threshold (<25%) based on Percent of Expected metric.

Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		Cigna Cigna PPO		UnitedHealthcare UnitedHealthcare Blue Cross	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
AdventHealth Castle Rock	A	●	●	●	●	●	●	●	●
AdventHealth Littleton	A	●	●	●	●	●	●	●	●
AdventHealth Parker	B	●	●	●	●	●	●	●	●
AdventHealth Porter	A	●	●	●	●	●	●	●	●
Children's Hospital Colorado — Anschutz Medical Campus, Aurora	N/A	●	●	●	●	●	●	●	●
CommonSpirit — St. Anthony Hospital	B	●	●	●	●	●	●	●	●
CommonSpirit — St. Anthony North Hospital	B	●	●	●	●	●	●	●	●
Denver Health Medical Center	A	●	●	●	●	●	●	●	●
Intermountain Health Platte Valley Hospital	A	●	●	●	●	●	●	●	●
Intermountain Health Saint Joseph Hospital	A	●	●	●	●	●	●	●	●
Lutheran Medical Center	A	●	●	●	●	●	●	●	●
National Jewish Health	N/A	●	●	●	●	●	●	●	●
North Suburban Medical Center	N/A	●	●	●	●	●	●	●	●
OrthoColorado Hospital at St. Anthony Medical Campus	N/A	●	●	●	●	●	●	●	●
Pennington St. Luke's Medical Center	A	●	●	●	●	●	●	●	●
Rosa Medical Center	A	●	●	●	●	●	●	●	●
SCL Health Community Hospital — Northglenn	N/A	●	●	●	●	●	●	●	●
Sky Ridge Medical Center	C	●	●	●	●	●	●	●	●
Swedish Medical Center	A	●	●	●	●	●	●	●	●
The Medical Center of Aurora	A	●	●	●	●	●	●	●	●
UHealth Broomfield Hospital	C	●	●	●	●	●	●	●	●
UHealth Highlands Ranch Hospital	N/A	●	●	●	●	●	●	●	●
University of Colorado Hospital Authority	D	●	●	●	●	●	●	●	●

Percent of Expected:

- 0-25% Generally unusable Recommend cost-level investigation
- 26-50% Moderately usable Recommend additional investigation
- 51-75% Generally usable Consider additional investigation
- 76-100% Highly usable

Dallas — Generally High Data Usability With Some Gaps

The HPT data in Dallas is stronger than some of the other regional markets, though gaps still exist.

Hospital	Leapfrog Hospital Safety Score	Aetna Choice POS II		Blue Cross Blue Shield of TX		Cigna Choice OAP		UnitedHealthcare UnitedChoice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Baylor Emergency Medical Center	N/A	●	●	●	●	●	●	●	●
Baylor Scott & White Emergency Hospital — Keller	N/A	●	●	●	●	●	●	●	●
Baylor Scott & White Heart and Vascular Hospital — Dallas	A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Centennial	A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Frisco	C	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Irving	A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Lake Pointe	A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — McKinney	A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Plano	A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Sunnyvale	D	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Trophy Club	N/A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Uptown	N/A	●	●	●	●	●	●	●	●
Baylor Scott & White Medical Center — Waxahachie	B	●	●	●	●	●	●	●	●
Baylor Scott & White Surgical Hospital — Las Colinas	N/A	●	●	●	●	●	●	●	●
Baylor Scott & White The Heart Hospital — Denton	N/A	●	●	●	●	●	●	●	●
Baylor Scott & White The Heart Hospital — Plano	N/A	●	●	●	●	●	●	●	●
Baylor University Medical Center	C	●	●	●	●	●	●	●	●
Carrollton Regional Medical Center	N/A	●	●	●	●	●	●	●	●
Children's Medical Center of Dallas	N/A	●	●	●	●	●	●	●	●
Children's Medical Center Plano	N/A	●	●	●	●	●	●	●	●
Cook Children's Medical Center	N/A	●	●	●	●	●	●	●	●
Cook Children's Medical Center — ProSPAR	N/A	●	●	●	●	●	●	●	●
Crescent Medical Center Lancaster	N/A	●	●	●	●	●	●	●	●

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Dallas Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Kaiser Blue Choice PPO		Cigna OAP		UnitedHealthcare UHC Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Dallas Medical Center	B	●	○	●	○	●	○	●	○
Dallas Regional Medical Center	C	●	○	●	○	●	○	●	○
Ennis Regional Medical Center	N/A	●	○	●	○	●	○	●	○
Hunt Regional Medical Center	C	●	○	●	○	●	○	●	○
Leggett Orthopedic Hospital — Carrollton	N/A	●	○	●	○	●	○	●	○
Mayhill Hospital	N/A	●	○	●	○	●	○	●	○
Medical City Dallas	C	●	○	●	○	●	○	●	○
Medical City Denton	A	●	○	●	○	●	○	●	○
Medical City Las Colinas	C	●	○	●	○	●	○	●	○
Medical City Lewisville	B	●	○	●	○	●	○	●	○
Medical City McKinney	B	●	○	●	○	●	○	●	○
Medical City Plano	C	●	○	●	○	●	○	●	○
Medical City Sachse	C	●	○	●	○	●	○	●	○
Methodist Charlton Medical Center	N/A	●	○	●	○	●	○	●	○
Methodist Dallas Medical Center	B	●	○	●	○	●	○	●	○
Methodist Hospital For Surgery	A	●	○	●	○	●	○	●	○
Methodist McKinney Hospital	N/A	●	○	●	○	●	○	●	○
Methodist Midbloom Medical Center	N/A	●	○	●	○	●	○	●	○
Methodist Richardson Medical Center	A	●	○	●	○	●	○	●	○
North Central Surgical Center LLP	A	●	○	●	○	●	○	●	○
Parkland Health	N/A	●	○	●	○	●	○	●	○
Scottish Rite Hospital For Children	D	○	○	○	○	○	○	○	○
Texas Health Center for Diagnostics & Surgery — Plano	N/A	●	○	●	○	●	○	●	○
Texas Health Hospital Frisco	N/A	●	○	●	○	●	○	●	○
Texas Health Hospital Rockwall	C	●	○	●	○	●	○	●	○
Texas Health Presbyterian Hospital Allen	C	●	○	●	○	●	○	●	○
Texas Health Presbyterian Hospital Dallas	D	○	○	○	○	○	○	○	○

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ○ 26-50% Moderately unusable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Dallas Hospital Transparency Data		Leapfrog Hospital Safety Score		Aetna Choice POS II		Kaiser Blue Choice PPO		Cigna Cigna OAP		UnitedHealthcare United Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Texas Health Presbyterian Hospital Denton	C	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Flower Mound	C	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Kaufman	B	●	●	●	●	●	●	●	●	●	●
Texas Health Presbyterian Hospital Plano	C	●	●	●	●	●	●	●	●	●	●
Texas Institute for Surgery at Texas Health Presbyterian Dallas	N/A	●	●	●	●	●	●	●	●	●	●
UT Southwestern University Hospital	A	●	●	●	●	●	●	●	●	●	●
UT Southwestern University Hospital — Zale Lipshy	A	●	●	●	●	●	●	●	●	●	●
White Rock Medical Center	D	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Chicago — Mostly Sparse Data Usability

The HPT data in Chicago appears to be the most sparsely populated across all 10 regional markets evaluated. There are, however, some pockets of usable data at Advocate, Loyola, and Northwestern.

Chicago Hospital Transparency Data	Leapfrog Hospital Safety Score		AAsa CHCA POS II		BCBS IL Provider Options		Cigna OAP		UnitedHealthcare UHC/Choice Plus	
	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Advocate Christ Medical Center	C									
Advocate Good Samaritan Hospital	C									
Advocate Illinois Masonic Medical Center	B									
Advocate Lutheran General Hospital	B									
Advocate South Suburban Hospital	B									
Advocate Trinity Hospital	C									
Ann & Robert H. Lurie Children's Hospital of Chicago	N/A									
Ascension Alexian Brothers Medical Center	C									
Ascension Resurrection	B									
Ascension Saint Alexius	B									
Ascension Saint Francis	A									
Ascension Saint Joseph — Joliet	C									
Ascension Saint Joseph Hospital — Chicago	C									
Ascension Saint Mary — Chicago	B									
Centegra Health System — Woodstock Hospital	N/A									
Community First Medical Center	D									
Edward Hospital	A									
Emmhuset Hospital	A									
Franciscan Health Olympia Fields	C									
Holy Cross Hospital	C									
Humboldt Park Health	C									
Insight Hospital and Medical Center Chicago	N/A									

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Chicago Hospital Transparency Data	Leapfrog Hospital Safety Score	Non-Choice POS II		BCBS-IL Participating Provider Options		Sign-On CAP		UnitedHealthcare UHC Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Jackson Park Hospital	Not Graded								
John H. Stroger, Jr. Hospital of Cook County	B								
La Rabida Children's Hospital	N/A								
Loyola Hospital	A								
Louis A. Weiss Memorial Hospital	D								
Loyola University Memorial Hospital	B								
Loyola University Medical Center	C								
Natchez Hospital	A								
MercyHealth Hospital and Medical Center — Harvard	N/A								
Morris Hospital & Healthcare Centers	A								
Mount Sinai Hospital	C								
NorthShore University HealthSystem Evanston Hospital	A								
Northwest Community Hospital	A								
Northwestern Medicine Central DuPage Hospital	A								
Northwestern Medicine McHenry Hospital	A								
Northwestern Medicine Palos Hospital	A								
Northwestern Memorial Hospital	A								
Oak Forest Hospital	N/A								
OSP Little Company of Mary Medical Center	B								
Provident Hospital of Cook County	N/A								
Rowland Community Hospital	D								
Rush Oak Park Hospital	B								
Rush University Medical Center	A								
Sacred Heart Hospital	N/A								
Saint Anthony Hospital	C								
Shawna Hospital for Children	N/A								
Silver Cross Hospital and Medical Centers	A								

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Chicago Hospital Transparency Data	Leapfrog Hospital Safety Score	Aona Choice POS II		BCBS-IL Participating Provider Options		Cigna Cigna OAP		UnitedHealthcare UHC Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
South Shore Hospital	A	●	●	●	●	●	●	●	●
Saint Mary's and Elizabeth Medical Center – Claremont Campus	N/A	●	●	●	●	●	●	●	●
St. Bernard Hospital and Health Care Center	A	●	●	●	●	●	●	●	●
Sveinash Hospital	C	●	●	●	●	●	●	●	●
The University of Chicago Medical Center	A	●	●	●	●	●	●	●	●
Thosok Memorial Hospital	C	●	●	●	●	●	●	●	●
Thosok Memorial Hospital Andersonville	N/A	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth Bolingbrook	A	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth Glenbrook	A	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth Hinsdale	A	●	●	●	●	●	●	●	●
UChicago Medicine AdventHealth La Grange	A	●	●	●	●	●	●	●	●
UChicago Medicine Ingalls Memorial Hospital	C	●	●	●	●	●	●	●	●
University of Illinois Hospital and Clinics	C	●	●	●	●	●	●	●	●
West Suburban Medical Center	D	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Atlanta — Lower Data Usability Than Other Regional Markets

The HPT data in Atlanta has an overall lower Percent of Expected than other regional markets in this report. Analysis of hospital submitted data resulted in a Percent of Expected below 25%. In Appendix 2, there was a deeper look at three of the larger facilities in this market (Emory University Hospital, Tanner Medical Center – Carrollton, and Wellstar Kennestone Medical Center) and identified a number of reasons for the lower Percent of Expected ratings. In particular, many of the hospitals did not post actual negotiated rates or percentage rates that are easily usable for comparison.

Atlanta Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem POS		Cigna Cigna OAP		UnitedHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Atlanta Medical Center – South Campus	N/A								
Children's Healthcare of Atlanta at Egleston Hospital	N/A								
Children's Healthcare of Atlanta at Scottish Rite Hospital	N/A								
Emory Decatur Hospital	C								
Emory Hilldale Hospital	B								
Emory Saint Joseph's Hospital of Atlanta, Inc.	C								
Emory University Hospital	C								
Emory University Hospital Midtown	C								
Grady Memorial Hospital	N/A								
Jasper Memorial Hospital	N/A								
Midtown Urology Surgical Center	N/A								
Morgan Medical Center	N/A								
Northeast Atlanta Vascular Care LLC	N/A								
Northeast Georgia Medical Center Barrow	Not Graded								
Northside Hospital	C								
Northside Hospital Cherokee	C								
Northside Hospital Daluth	C								
Northside Hospital Forsyth	C								
Northside Hospital Gwinnett	C								

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Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

Atlanta Hospital Transparency Data	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem POS		Cigna Cigna OAP		UnitedHealthcare UnitedHealthcare POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Northwest Atlanta Vascular Care LLC	N/A								
Piedmont Atlanta Hospital	A								
Piedmont Cantonville Medical Center	B								
Piedmont Eastside Medical Center	B								
Piedmont Fayette Hospital	A								
Piedmont Henry Hospital	A								
Piedmont Mountzside Hospital, Inc.	B								
Piedmont Newnan Hospital, Inc	B								
Piedmont Newton Hospital	A								
Piedmont Rockdale Hospital	B								
Piedmont Walton Hospital, Inc	B								
Southeast Atlanta Vascular Care, LLC	N/A								
Southeastern Regional Medical Center, Inc.	N/A								
Southern Regional Medical Center	C								
Southwest Atlanta Vascular Care	N/A								
Tanner Medical Center - Carrollton	C								
Tanner Medical Center - Villa Rica	A								
Warm Springs Medical Center	N/A								
Wellstar Cobb Medical Center	B								
Wellstar Douglas Medical Center	B								
Wellstar Kennestone Regional Medical Center	B								
Wellstar North Fulton Medical Center	C								
Wellstar Paulding Hospital	A								
Wellstar Spalding Hospital	B								
Wellstar Sylvan Grove Medical Center	N/A								
Wesley Woods Geriatric Hospital	N/A								

Percent of Expected: ● 0-25% Generally unusable Recommend cost-level investigation ● 26-50% Moderately usable Recommend additional investigation ● 51-75% Generally usable Consider additional investigation ● 76-100% Highly usable

New York City/Northern New Jersey — Reasonably Good Data Usability for Many Facilities

Similar to the TIC data in this market, the HPT data usability is reasonably good for many facilities in this regional market. Most of the observed gaps (>25%) based on Percent of Expected are based on service area differences since this MSA includes two different states.

Hospital	Leapfrog Hospital Safety Score	Aetna Choice POS II		Anthem Anthem PPO		Cigna Cigna OAP		EmblemHealth National / Bridge		Horizon BCBS NJ Managed Care		HighHealthcare UHC Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Bergen New Bridge Medical Center	N/A	●	○	●	●	●	●	●	●	●	●	●	○
Blythedale Children's Hospital	N/A	●	○	●	●	●	●	●	●	●	●	●	○
BronxCare Health System	C	○	○	○	○	○	○	○	○	○	○	○	○
Brookdale Hospital Medical Center	D	●	○	●	○	●	○	●	○	●	○	○	○
Brooklyn Hospital Center — Downtown Campus	B	●	○	●	○	●	○	●	○	●	○	○	○
Brooklyn Hospital Center — Bayonne Medical Center	C	●	○	●	○	●	○	●	○	●	○	○	○
CarePoint Health — Christ Hospital	Not Graded	○	○	○	○	○	○	○	○	○	○	○	○
Hoboken University Medical Center	C	●	○	●	○	●	○	●	○	●	○	○	○
Community Hospital At Dobbs Ferry	N/A	●	○	●	○	●	○	●	○	●	○	○	○
Englewood Hospital and Medical Center	A	●	○	●	○	●	○	●	○	●	○	○	○
Flushing Hospital Medical Center	A	●	○	●	○	●	○	●	○	●	○	○	○
Forest Hills Hospital	N/A	●	○	●	○	●	○	●	○	●	○	○	○
Good Samaritan Hospital of Suffern	D	●	○	●	○	●	○	●	○	●	○	○	○
Hackensack Meridian Health	A	●	○	●	○	●	○	●	○	●	○	○	○
Pascack Valley Medical Center	A	●	○	●	○	●	○	●	○	●	○	○	○
Hackensack University Medical Center	A	●	○	●	○	●	○	●	○	●	○	○	○
Helen Hayes Hospital	N/A	●	○	●	○	●	○	●	○	●	○	○	○
Holy Name Medical Center	A	●	○	●	○	●	○	●	○	●	○	○	○
Hospital For Special Surgery	N/A	●	○	●	○	●	○	●	○	●	○	○	○

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Percent of Expected: ● 0-25% Generally unusable Recurrence code level investigation ○ 26-50% Moderately usable Recurrence additional investigation ● 51-75% Generally usable Recurrence additional investigation ● 76-100% Highly usable

NYC/Northern New Jersey Hospital Transparency Data	Leaflet Hospital Score	Aetna Choice POS II		Aetna Wellness PPO		Cigna OIGM OAP		EmblemHealth Network / Bridge		Horizon BCBS NJ Managed Care		UnitedHealthcare United Choice Plus	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
Hudson Regional Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Interfaith Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Jacobi Medical Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Jamaica Hospital Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Jersey City Medical Center	B	●	●	●	●	●	●	●	●	●	●	●	●
Kings County Hospital Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Kingsbrook Jewish Medical Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Lenox Hill Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Long Island Jewish Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Lutheran Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Maimonides Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Maimonides Midwood Community Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
Memorial Sloan Kettering Cancer Center	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Monell Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
Monterefore Mount Vernon Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
Monterefore New Rochelle Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Monterefore Nyack Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Mount Sinai Beth Israel	C	●	●	●	●	●	●	●	●	●	●	●	●
Mount Sinai Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Mount Sinai West	B	●	●	●	●	●	●	●	●	●	●	●	●
New York Downtown Hospital	N/A	●	●	●	●	●	●	●	●	●	●	●	●
New York Eye and Ear Infirmary	N/A	●	●	●	●	●	●	●	●	●	●	●	●
New York Presbyterian Hospital — Weill Cornell Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
New York Presbyterian Hospital — Lawrence Hospital — P. D'Amico Brooklyn	A	●	●	●	●	●	●	●	●	●	●	●	●
Methodist Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
NewYork-Presbyterian Hudson Valley Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
NewYork-Presbyterian — Queens	A	●	●	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unable to recommend cost-level investigation ● 26-50% Moderately unable to recommend additional investigation ● 51-75% Generally usable consider additional investigation ● 76-100% Highly usable

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Hospital	Learning Health System Score	Aetna Choice POS II		Aetna Health PPO		Cigna High DAP		EmblemHealth National / Bridge		Horizon BCBS NJ Managed Care		UnitedHealthcare United Choice POS	
		In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient	In-patient	Out-patient
North Central Bronx Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
Northern Westchester Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
NYC Health + Hospitals — Elmhurst	C	●	●	●	●	●	●	●	●	●	●	●	●
NYC Health + Hospitals — Harlem	C	●	●	●	●	●	●	●	●	●	●	●	●
NYC Health + Hospitals — Lincoln	C	●	●	●	●	●	●	●	●	●	●	●	●
NYC Health + Hospitals — Metropolitan	B	●	●	●	●	●	●	●	●	●	●	●	●
NYC Health + Hospitals — Metropolitan	C	●	●	●	●	●	●	●	●	●	●	●	●
South Brooklyn Health	C	●	●	●	●	●	●	●	●	●	●	●	●
NYC Health + Hospitals — Bellevue	A	●	●	●	●	●	●	●	●	●	●	●	●
NYU Langone Hospitals	B	●	●	●	●	●	●	●	●	●	●	●	●
Palladium Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Phelps Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Putnam Hospital Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Queens Hospital Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Richmond University Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Saint Joseph's Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
St. John's Episcopal Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
St. Joseph's Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
St. Joseph's University Medical Center	A	●	●	●	●	●	●	●	●	●	●	●	●
St. Barnabas Hospital	D	●	●	●	●	●	●	●	●	●	●	●	●
St. John's Riverside Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
St. Mary's General Hospital	A	●	●	●	●	●	●	●	●	●	●	●	●
Staten Island University Hospital	C	●	●	●	●	●	●	●	●	●	●	●	●
University Hospital of Brooklyn	C	●	●	●	●	●	●	●	●	●	●	●	●
University Hospital of Brooklyn valley Hospital	B	●	●	●	●	●	●	●	●	●	●	●	●
Westchester Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●
White Plains Hospital Center	A	●	●	●	●	●	●	●	●	●	●	●	●
Woodhull Medical & Mental Health Center	D	●	●	●	●	●	●	●	●	●	●	●	●
Wyckoff Heights Medical Center	C	●	●	●	●	●	●	●	●	●	●	●	●

Percent of Expected: ● 0-25% Generally unable to recommend cost-level investigation ● 26-50% Moderately unable to recommend additional investigation ● 51-75% Generally usable consider additional investigation ● 76-100% Highly usable

Appendix 5: Tables of Regional Prices for Specific Codes

The tables in this Appendix contain payment rate benchmarks based on code level information from the TIC and HPT files. For these comparative price benchmarks, a sample of billing codes that were prevalent in employer claims data and generally found with a robust sample of data points from the TIC and HPT files were selected for these benchmarks. However, there are some instances where there is not a robust amount of data, and, in these cases, the benchmarks are less credible, represented by number of records.

These benchmarks are intended to provide a summary of the range of negotiated rates for each code. Since the data is often imperfect, it is suggested that readers focus on the data ranging between the 25th and 75th percentiles when assessing reasonableness of costs rather than the minimum and maximum, which may represent outlier data points.

The information in the following tables is limited to the group plans outlined earlier in the report. Data supporting these tables reflects all rates that exist for specific billing codes in the specific region for the primary group networks analyzed, with some adjustments as described below. Below outlines key information about the data underlying the benchmark prices:

- The reported benchmark prices represent data posted at a point in time. TIC data is updated monthly, and HPT data is updated at least annually. The reported prices can change as newer files are posted by payers and hospitals.
- For HPT and TIC facility data, values were excluded if they were less than 100% of CMS Medicare or above 1000% of CMS Medicare for each code to mitigate the impact of data that may be inaccurately reported. We did not apply this limitation to Ambulatory Surgical Center (ASC) data.
- There was not always a rate provided for each provider, network, and code combination. When specific payer/provider data is missing, from either the TIC or HPT data, there can be some distortion in benchmark prices. For example:

- In cases where payers are reporting a percent of charge or a custom code where a negotiated rate cannot be derived, the benchmarks will not represent negotiated rates for those payers in the TIC data, even though those same payers might be represented in the HPT data. Conversely, there will be instances where payers are reporting negotiated rates at a specific facility in the TIC files, but the facility might not post negotiated rates for those payers in the HPT files. As a result, the benchmark range for TIC data and HPT data for the same code may not align because the underlying data for each is different.
- Conversely, there were instances when more than one rate in the files was observed for the same provider, network, and code combination. In these cases, all rates that met the criteria above (between 100% and 1,000% of Medicare) are included in the following tables. No filtering occurred due to multiple rates.
- In some regional markets (e.g., Phoenix), there are a small number of large health systems with multiple facilities that could make up a sizable percentage of the benchmark data, while other regional markets (e.g., Northern California) include a vast number of facilities with incredibly different characteristics. The market-specific differences have an impact on the range of rates being reported.
- Number of records of underlying the data in the table are included as a column, so readers can understand the number of unique providers, networks, and code combinations available from each dataset to help assess the credibility of the range of prices. When the number of records are low, more caution should be applied to interpretation of the data.

Note that some of the values reported are based on a very small sample of data points that may not be reflective of the true range of costs for those services. Please exercise caution when reviewing these benchmarks.

Tables in this section represent negotiated payment rates that were provided as a dollar rate with a rate methodology of 'case rate' or 'negotiated fee'. If a payer or hospital posted a percent or charge value, we only included the data point if a negotiated rate could be derived by matching to a billed charge amount from the HPT files.

These tables do not include per diem rates, capitated rates, or bundled payment rates. Children's Hospitals are also excluded from these tables since negotiated rates for pediatric and adult codes are different. Critical Access Hospitals were also excluded from the benchmarks due to the variation in cost at these hospitals.

Readers should consider all of the above factors when evaluating the data.

Seattle/Puget Sound

Figure 1a. Comparison of Inpatient Maternity Rates for Payer and Hospital Data

Market Benchmarks - Inpatient, Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	121	\$14,560	\$26,155	\$34,302	\$39,857	\$66,947
787	Cesarean section w/o sterilization w Cc	126	\$11,427	\$17,423	\$22,054	\$25,628	\$43,990
788	Cesarean section w/o sterilization w/o Cc/Mcc	126	\$9,650	\$15,568	\$18,251	\$22,219	\$37,482
806	Vaginal delivery w/o sterilization/d&c w Cc	127	\$7,256	\$11,081	\$14,460	\$17,430	\$28,820
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	126	\$6,959	\$10,637	\$12,883	\$15,447	\$25,382
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	46	\$18,828	\$30,249	\$31,880	\$37,507	\$44,647
787	Cesarean section w/o sterilization w Cc	54	\$11,070	\$16,417	\$20,244	\$22,882	\$26,824
788	Cesarean section w/o sterilization w/o Cc/Mcc	54	\$9,650	\$14,095	\$16,467	\$18,910	\$21,820
806	Vaginal delivery w/o sterilization/d&c w Cc	49	\$7,093	\$12,041	\$14,216	\$15,981	\$19,056
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	53	\$6,510	\$10,683	\$12,430	\$13,687	\$16,698

Seattle/Puget Sound (continued)
 Figure 1b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	62	\$15,774	\$32,926	\$44,674	\$53,385	\$73,395
27447	Total knee arthroplasty	62	\$15,774	\$33,111	\$44,674	\$53,746	\$73,395
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	28	\$16,927	\$25,690	\$40,932	\$55,309	\$81,206
27447	Total knee arthroplasty	28	\$16,927	\$25,690	\$40,932	\$55,309	\$81,206
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	162	\$6,459	\$9,566	\$13,418	\$18,386	\$23,622
27447	Total knee arthroplasty	162	\$6,719	\$9,213	\$12,714	\$18,386	\$23,692

Seattle/Puget Sound (continued)
 Figure 1c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	72	\$919	\$2,041	\$2,698	\$8,646
45378	Diagnostic colonoscopy	73	\$944	\$2,240	\$2,742	\$8,646
45380	Colonoscopy and biopsy	67	\$1,201	\$2,652	\$3,221	\$8,646
45385	Colonoscopy w/lesion removal	68	\$1,356	\$2,609	\$3,268	\$8,646
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	57	\$941	\$2,686	\$3,592	\$8,242
45378	Diagnostic colonoscopy	61	\$949	\$2,634	\$3,343	\$8,242
45380	Colonoscopy and biopsy	52	\$1,225	\$3,356	\$4,271	\$8,242
45385	Colonoscopy w/lesion removal	54	\$1,225	\$3,055	\$4,271	\$8,242
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	245	\$445	\$578	\$712	\$1,000
45378	Diagnostic colonoscopy	259	\$432	\$583	\$749	\$1,060
45380	Colonoscopy and biopsy	269	\$524	\$686	\$834	\$1,173
45385	Colonoscopy w/lesion removal	259	\$524	\$675	\$813	\$1,147

Seattle/Puget Sound (continued)

Figure 1d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	51	\$56	\$59	\$60	\$112	\$185
J3380	Injection, vedolizumab	52	\$21	\$22	\$22	\$36	\$64
J9271	Inj pembrolizumab	52	\$49	\$55	\$58	\$67	\$170
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	36	\$59	\$60	\$71	\$147	\$288
J3380	Injection, vedolizumab	36	\$21	\$24	\$30	\$53	\$106
J9271	Inj pembrolizumab	36	\$52	\$52	\$61	\$86	\$257

Seattle/Puget Sound (continued)

Figure 1f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	68	\$218	\$778	\$968	\$1,354	\$2,370
99284	Emergency dept visit	69	\$371	\$1894	\$1,575	\$2,178	\$3,873
99285	Emergency dept visit	68	\$915	\$1,752	\$2,315	\$3,822	\$5,276
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	67	\$286	\$784	\$1,083	\$1,370	\$2,240
99284	Emergency dept visit	68	\$460	\$1,291	\$1,671	\$2,268	\$3,873
99285	Emergency dept visit	68	\$667	\$1,914	\$2,571	\$3,759	\$5,592

Seattle/Puget Sound (continued)
 Figure 1g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	5	\$143	\$148	\$152	\$176 \$186
99213	Office O/P Est. Low 20-29 Min	17	\$148	\$153	\$178	\$185 \$298
99214	Office O/P Est. Med 30-39 Min	32	\$132	\$163	\$189	\$252 \$417
99215	Office O/P Est. Hi 40-54 Min	44	\$137	\$179	\$237	\$297 \$584
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	2	\$156	\$157	\$157	\$158 \$159
99213	Office O/P Est. Low 20-29 Min	5	\$186	\$200	\$261	\$294 \$306
99214	Office O/P Est. Med 30-39 Min	13	\$153	\$153	\$197	\$230 \$476
99215	Office O/P Est. Hi 40-54 Min	13	\$175	\$175	\$197	\$287 \$669
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	8,975	\$38	\$65	\$74	\$83 \$255
99213	Office O/P Est. Low 20-29 Min	10,537	\$66	\$103	\$118	\$134 \$409
99214	Office O/P Est. Med 30-39 Min	10,703	\$99	\$146	\$167	\$181 \$577
99215	Office O/P Est. Hi 40-54 Min	9,631	\$144	\$204	\$235	\$278 \$812

Oregon

Figure 2a. Comparison of Inpatient Maternity Rates

Market Benchmarks - Inpatient Maternity Rates

Payer Transparency Data - Outpatient Facility						
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile
786	Cesarean section w/o sterilization w Mcc	102	\$15,871	\$30,183	\$35,105	\$43,811
787	Cesarean section w/o sterilization w Cc	109	\$10,947	\$20,087	\$22,419	\$30,527
788	Cesarean section w/o sterilization w/o Cc/Mcc	108	\$10,947	\$16,926	\$19,790	\$26,171
806	Vaginal delivery w/o sterilization/d&c w Cc	105	\$7,746	\$15,523	\$15,109	\$18,691
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	104	\$7,746	\$12,312	\$13,523	\$16,672
Hospital Transparency Data - Outpatient Facility						
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile
786	Cesarean section w/o sterilization w Mcc	97	\$17,750	\$32,404	\$38,060	\$40,898
787	Cesarean section w/o sterilization w Cc	97	\$10,860	\$21,702	\$26,456	\$30,755
788	Cesarean section w/o sterilization w/o Cc/Mcc	96	\$10,860	\$17,974	\$22,163	\$25,017
806	Vaginal delivery w/o sterilization/d&c w Cc	99	\$7,448	\$15,079	\$16,843	\$20,394
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	100	\$7,448	\$13,344	\$16,476	\$17,955
						\$20,792

Oregon (continued)

Figure 2b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	70	\$14,614	\$31,792	\$50,321	\$66,004	\$83,988
27447	Total knee arthroplasty	70	\$14,614	\$30,543	\$50,321	\$66,004	\$83,988
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	10	\$14,638	\$15,196	\$17,048	\$23,311	\$47,817
27447	Total knee arthroplasty	6	\$15,988	\$15,273	\$36,185	\$47,351	\$47,817
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	252	\$6,267	\$11,865	\$15,073	\$18,478	\$44,245
27447	Total knee arthroplasty	256	\$6,080	\$11,653	\$14,954	\$18,195	\$38,915

Oregon (continued)

Figure 2c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	81	\$971	\$2,245	\$3,201	\$5,517 \$7,355
45378	Diagnostic colonoscopy	71	\$1,202	\$2,384	\$3,266	\$5,188 \$7,283
45380	Colonoscopy and biopsy	67	\$1,475	\$2,925	\$4,165	\$4,987 \$10,074
45385	Colonoscopy w/lesion removal	71	\$1,475	\$2,823	\$3,836	\$4,987 \$10,074
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	64	\$961	\$1,982	\$2,713	\$4,000 \$8,500
45378	Diagnostic colonoscopy	61	\$1,129	\$2,185	\$2,972	\$4,027 \$6,536
45380	Colonoscopy and biopsy	32	\$1,477	\$2,376	\$3,083	\$3,718 \$8,258
45385	Colonoscopy w/lesion removal	39	\$1,477	\$2,336	\$2,955	\$3,830 \$8,382
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	341	\$413	\$685	\$938	\$1,094 \$3,356
45378	Diagnostic colonoscopy	345	\$436	\$683	\$842	\$1,097 \$3,356
45380	Colonoscopy and biopsy	338	\$515	\$781	\$1,000	\$1,255 \$3,356
45385	Colonoscopy w/lesion removal	339	\$540	\$802	\$1,004	\$1,263 \$3,356

Oregon (continued)

Figure 2d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	35	\$55	\$60	\$65	\$79	\$177
J3380	Injection, vedolizumab	36	\$21	\$22	\$25	\$29	\$66
J9271	Inj pembrolizumab	36	\$43	\$54	\$62	\$77	\$172
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	22	\$60	\$85	\$129	\$239	\$373
J3380	Injection, vedolizumab	27	\$22	\$31	\$44	\$86	\$162
J9271	Inj pembrolizumab	15	\$64	\$101	\$127	\$151	\$271

Oregon (continued)
 Figure 2e. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	87	\$12	\$18	\$32	\$41 \$105
80061	Lipid panel	90	\$15	\$23	\$40	\$51 \$123
85025	Complete cbc w/auto diff wbc	80	\$9	\$13	\$23	\$29 \$71
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	138	\$13	\$36	\$44	\$76 \$105
80061	Lipid panel	171	\$14	\$40	\$48	\$63 \$137
85025	Complete cbc w/auto diff wbc	134	\$9	\$18	\$29	\$50 \$73
Payer Transparency Data - Outpatient Non-Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	2,862	\$11	\$12	\$13	\$14 \$68
80061	Lipid panel	2,623	\$13	\$15	\$16	\$18 \$86
85025	Complete cbc w/auto diff wbc	2,721	\$8	\$9	\$9	\$11 \$50

Oregon (continued)

Figure 2f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	73	\$520	\$863	\$1,036	\$1,330	\$2,165
99284	Emergency dept visit	68	\$817	\$1,334	\$1,663	\$1,882	\$3,663
99285	Emergency dept visit	67	\$1,173	\$1,925	\$2,529	\$2,824	\$5,929
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	113	\$467	\$864	\$1,069	\$1,182	\$2,353
99284	Emergency dept visit	114	\$735	\$1,397	\$1,734	\$1,849	\$3,731
99285	Emergency dept visit	123	\$1,253	\$1,873	\$2,551	\$2,656	\$6,199

Oregon (continued)
 Figure 2g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	26	\$143	\$237	\$324	\$424
99213	Office O/P Est. Low 20-29 Min	47	\$134	\$178	\$230	\$364
99214	Office O/P Est. Med 30-39 Min	65	\$131	\$184	\$240	\$325
99215	Office O/P Est. Hi 40-54 Min	69	\$159	\$208	\$323	\$440
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	169	\$125	\$217	\$340	\$424
99213	Office O/P Est. Low 20-29 Min	177	\$125	\$226	\$344	\$485
99214	Office O/P Est. Med 30-39 Min	147	\$125	\$283	\$445	\$536
99215	Office O/P Est. Hi 40-54 Min	142	\$125	\$286	\$483	\$529
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	15,638	\$35	\$63	\$77	\$98
99213	Office O/P Est. Low 20-29 Min	18,404	\$65	\$109	\$126	\$166
99214	Office O/P Est. Med 30-39 Min	17,687	\$96	\$154	\$185	\$243
99215	Office O/P Est. Hi 40-54 Min	16,027	\$141	\$212	\$266	\$352

Northern California
Figure 3a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	165	\$8,046	\$37,516	\$45,884	\$51,313	\$78,413
787	Cesarean section w/o sterilization w Cc	189	\$8,046	\$23,763	\$43,632	\$48,728	\$59,249
788	Cesarean section w/o sterilization w/o Cc/Mcc	183	\$8,046	\$21,422	\$27,199	\$31,764	\$58,688
806	Vaginal delivery w/o sterilization/d&c: w Cc	189	\$8,046	\$17,603	\$26,460	\$31,062	\$36,848
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	183	\$7,881	\$16,352	\$18,388	\$20,903	\$36,848
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	43	\$11,889	\$22,447	\$25,264	\$43,074	\$91,039
787	Cesarean section w/o sterilization w Cc	58	\$11,889	\$16,996	\$18,934	\$25,522	\$87,987
788	Cesarean section w/o sterilization w/o Cc/Mcc	60	\$10,850	\$15,480	\$18,789	\$25,273	\$74,399
806	Vaginal delivery w/o sterilization/d&c: w Cc	58	\$9,180	\$11,726	\$14,121	\$20,926	\$35,641
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	61	\$7,150	\$11,076	\$13,267	\$18,683	\$33,430

Northern California (continued)
 Figure 3b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	67	\$15,877	\$22,981	\$33,161	\$42,831	\$146,993
27447	Total knee arthroplasty	82	\$15,877	\$22,636	\$30,632	\$42,338	\$120,597
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	76	\$15,284	\$23,951	\$36,161	\$47,527	\$146,993
27447	Total knee arthroplasty	84	\$15,284	\$23,851	\$35,855	\$45,970	\$120,597
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	207	\$6,365	\$8,149	\$10,506	\$18,000	\$36,870
27447	Total knee arthroplasty	292	\$6,200	\$8,087	\$10,835	\$15,922	\$37,203

Northern California (continued)

Figure 3c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	225	\$1,126	\$2,497	\$4,209	\$7,112 \$11,400
45378	Diagnostic colonoscopy	224	\$1,239	\$2,699	\$4,241	\$6,643 \$12,301
45380	Colonoscopy and biopsy	241	\$1,713	\$2,759	\$4,696	\$7,795 \$16,320
45385	Colonoscopy w/lesion removal	239	\$1,341	\$2,797	\$4,696	\$7,602 \$16,320
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	185	\$1,268	\$2,532	\$3,759	\$6,433 \$10,817
45378	Diagnostic colonoscopy	180	\$1,541	\$2,671	\$3,584	\$5,451 \$12,290
45380	Colonoscopy and biopsy	194	\$1,729	\$3,018	\$4,580	\$7,013 \$15,538
45385	Colonoscopy w/lesion removal	188	\$1,845	\$3,072	\$4,717	\$7,096 \$15,538
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	570	\$444	\$775	\$1,092	\$1,768 \$8,765
45378	Diagnostic colonoscopy	578	\$430	\$905	\$1,150	\$1,851 \$8,765
45380	Colonoscopy and biopsy	554	\$505	\$854	\$1,198	\$1,908 \$8,765
45385	Colonoscopy w/lesion removal	546	\$525	\$889	\$1,228	\$1,916 \$8,765

Northern California (continued)
 Figure 3d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	140	\$59	\$75	\$96	\$120	\$330
J3380	Injection, vedolizumab	141	\$22	\$32	\$39	\$47	\$150
J9271	Inj pembrolizumab	155	\$43	\$66	\$89	\$100	\$335
Hospital Transparency Data							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	78	\$61	\$84	\$99	\$153	\$225
J3380	Injection, vedolizumab	104	\$17	\$35	\$41	\$50	\$120
J9271	Inj pembrolizumab	91	\$46	\$74	\$89	\$134	\$327

Northern California (continued)
 Figure 3e. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab							
Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	168	\$11	\$16	\$30	\$57	\$107
80061	Lipid panel	184	\$14	\$21	\$43	\$71	\$135
85025	Complete cbc w/auto diff wbc	173	\$9	\$11	\$23	\$42	\$79
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	168	\$11	\$15	\$32	\$55	\$104
80061	Lipid panel	266	\$13	\$17	\$37	\$71	\$135
85025	Complete cbc w/auto diff wbc	120	\$9	\$12	\$24	\$40	\$80
Payer Transparency Data - Outpatient Non-Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	4,069	\$11	\$12	\$15	\$25	\$96
80061	Lipid panel	3,769	\$13	\$16	\$20	\$36	\$115
85025	Complete cbc w/auto diff wbc	4,007	\$9	\$9	\$11	\$17	\$63

Northern California (continued)

Figure 3f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Injection, ocrelizumab, 1 mg	140	\$59	\$75	\$96	\$120	\$330
99284	Injection, vedolizumab	141	\$22	\$32	\$39	\$47	\$150
99285	Inj pembrolizumab	155	\$43	\$66	\$89	\$100	\$335
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	195	\$213	\$1,346	\$1,876	\$2,080	\$3,253
99284	Emergency dept visit	188	\$444	\$2,207	\$3,010	\$3,530	\$4,077
99285	Emergency dept visit	218	\$727	\$3,084	\$4,563	\$5,328	\$7,043

Northern California (continued)
 Figure 3g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	40	\$151	\$194	\$214	\$319 \$1,018
99213	Office O/P Est. Low 20-29 Min	58	\$144	\$191	\$255	\$307 \$1,124
99214	Office O/P Est. Med 30-39 Min	84	\$147	\$208	\$273	\$428 \$1,324
99215	Office O/P Est. Hi 40-54 Min	96	\$154	\$209	\$281	\$418 \$918
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	176	\$143	\$225	\$288	\$399 \$1,724
99213	Office O/P Est. Low 20-29 Min	218	\$155	\$219	\$265	\$411 \$1,552
99214	Office O/P Est. Med 30-39 Min	209	\$155	\$239	\$340	\$477 \$1,697
99215	Office O/P Est. Hi 40-54 Min	197	\$151	\$259	\$401	\$571 \$1,729
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	10,079	\$36	\$67	\$79	\$113 \$282
99213	Office O/P Est. Low 20-29 Min	11,383	\$67	\$101	\$127	\$184 \$457
99214	Office O/P Est. Med 30-39 Min	11,516	\$100	\$148	\$183	\$265 \$660
99215	Office O/P Est. Hi 40-54 Min	10,114	\$147	\$218	\$248	\$409 \$881

Southern California
Figure 4a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	203	\$5,184	\$19,525	\$26,541	\$37,958	\$84,903
787	Cesarean section w/o sterilization w Cc	292	\$5,184	\$14,507	\$18,791	\$24,285	\$55,789
788	Cesarean section w/o sterilization w/o Cc/Mcc	280	\$5,184	\$12,087	\$16,700	\$21,481	\$47,535
806	Vaginal delivery w/o sterilization/d&c: w Cc	270	\$5,184	\$10,218	\$13,847	\$17,189	\$38,019
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	274	\$5,184	\$9,845	\$12,797	\$16,136	\$66,312
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	113	\$7,978	\$18,494	\$23,728	\$44,609	\$67,835
787	Cesarean section w/o sterilization w Cc	162	\$7,978	\$19,821	\$16,680	\$25,330	\$56,331
788	Cesarean section w/o sterilization w/o Cc/Mcc	188	\$7,978	\$14,444	\$14,810	\$21,656	\$85,658
806	Vaginal delivery w/o sterilization/d&c: w Cc	170	\$6,609	\$9,651	\$11,647	\$18,388	\$48,730
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	185	\$6,609	\$9,124	\$10,987	\$16,311	\$45,076

Southern California (continued)

Figure 4b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics						
HCPCS	Description	Payer Transparency Data - Outpatient Facility				
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
27130	Total hip arthroplasty	111	\$7,694	\$17,843	\$22,179	\$33,843 \$67,509
27447	Total knee arthroplasty	128	\$9,528	\$17,688	\$21,190	\$32,022 \$67,509
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Payer Transparency Data - Outpatient Facility				
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
27130	Total hip arthroplasty	45	\$15,839	\$19,733	\$24,666	\$34,526 \$86,019
27447	Total knee arthroplasty	62	\$15,353	\$19,667	\$22,179	\$31,524 \$71,707
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Payer Transparency Data - Ambulatory Surgical Center				
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
27130	Total hip arthroplasty	416	\$6,261	\$7,852	\$12,543	\$17,224 \$37,511
27447	Total knee arthroplasty	447	\$6,075	\$7,500	\$10,835	\$16,928 \$36,743

Southern California (continued)
 Figure 4c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	394	\$985	\$2,757	\$4,044	\$5,683	\$9,674
45378	Diagnostic colonoscopy	395	\$1,008	\$2,750	\$3,926	\$5,478	\$9,674
45380	Colonoscopy and biopsy	419	\$1,256	\$2,878	\$4,153	\$5,968	\$13,280
45385	Colonoscopy w/lesion removal	420	\$1,256	\$2,872	\$4,153	\$5,957	\$13,280
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	258	\$1,210	\$2,536	\$3,715	\$5,269	\$9,880
45378	Diagnostic colonoscopy	279	\$991	\$2,669	\$3,743	\$5,058	\$9,980
45380	Colonoscopy and biopsy	255	\$1,200	\$2,827	\$3,858	\$5,108	\$13,280
45385	Colonoscopy w/lesion removal	264	\$1,299	\$2,862	\$3,839	\$5,139	\$13,280
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	1,212	\$442	\$653	\$858	\$1,275	\$9,682
45378	Diagnostic colonoscopy	1,217	\$427	\$675	\$887	\$1,339	\$9,682
45380	Colonoscopy and biopsy	1,122	\$503	\$729	\$949	\$1,417	\$9,682
45385	Colonoscopy w/lesion removal	1,110	\$525	\$750	\$997	\$1,447	\$9,682

Southern California (continued)

Figure 4d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	247	\$48	\$63	\$73	\$118	\$626
J3380	Injection, vedolizumab	247	\$17	\$23	\$32	\$44	\$231
J9271	Inj pembrolizumab	265	\$31	\$59	\$66	\$95	\$613
Hospital Transparency Data							
HCPCS	Description	Hospital Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	81	\$44	\$61	\$101	\$148	\$376
J3380	Injection, vedolizumab	94	\$18	\$25	\$35	\$53	\$139
J9271	Inj pembrolizumab	116	\$31	\$58	\$92	\$129	\$389

Southern California (continued)
 Figure 4e. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab							
Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	311	\$9	\$17	\$29	\$51	\$105
80061	Lipid panel	329	\$11	\$22	\$36	\$64	\$133
85025	Complete cbc w/auto diff wbc	315	\$6	\$12	\$21	\$38	\$77
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	254	\$11	\$16	\$27	\$54	\$103
80061	Lipid panel	405	\$14	\$20	\$37	\$76	\$133
85025	Complete cbc w/auto diff wbc	269	\$9	\$12	\$21	\$42	\$76
Payer Transparency Data - Outpatient Non-Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	5,900	\$11	\$13	\$14	\$17	\$68
80061	Lipid panel	6,081	\$13	\$16	\$18	\$26	\$115
85025	Complete cbc w/auto diff wbc	5,510	\$9	\$9	\$10	\$13	\$50

Southern California (continued)

Figure 4f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Injection, ocrelizumab, 1 mg	233	\$160	\$997	\$1,501	\$2,080	\$3,092
99284	Injection, vedolizumab	202	\$302	\$1,331	\$2,085	\$2,867	\$4,384
99285	Inj pembrolizumab	245	\$405	\$2,090	\$3,073	\$4,397	\$6,683
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	319	\$307	\$892	\$1,323	\$1,618	\$2,630
99284	Emergency dept visit	320	\$485	\$1,344	\$1,972	\$2,466	\$4,124
99285	Emergency dept visit	381	\$966	\$1,990	\$2,841	\$4,081	\$7,236

Southern California (continued)
 Figure 4g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	50	\$32	\$159	\$171	\$228 \$752
99213	Office O/P Est. Low 20-29 Min	60	\$62	\$186	\$203	\$283 \$832
99214	Office O/P Est. Med 30-39 Min	72	\$91	\$192	\$236	\$383 \$1,344
99215	Office O/P Est. Hi 40-54 Min	76	\$108	\$167	\$216	\$352 \$1,211
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	249	\$140	\$187	\$228	\$301 \$1,347
99213	Office O/P Est. Low 20-29 Min	300	\$142	\$206	\$265	\$365 \$1,254
99214	Office O/P Est. Med 30-39 Min	319	\$142	\$218	\$310	\$444 \$1,493
99215	Office O/P Est. Hi 40-54 Min	304	\$144	\$249	\$364	\$553 \$1,168
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	12,191	\$36	\$65	\$75	\$92 \$278
99213	Office O/P Est. Low 20-29 Min	12,738	\$67	\$104	\$121	\$149 \$457
99214	Office O/P Est. Med 30-39 Min	12,884	\$99	\$150	\$175	\$211 \$663
99215	Office O/P Est. Hi 40-54 Min	11,632	\$148	\$214	\$237	\$290 \$889

Phoenix

Figure 5a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	142	\$17,789	\$20,383	\$27,084	\$40,949	\$53,055
787	Cesarean section w/o sterilization w Cc	167	\$9,081	\$13,947	\$19,510	\$25,887	\$34,862
788	Cesarean section w/o sterilization w/o Cc/Mcc	167	\$8,208	\$12,647	\$16,935	\$22,448	\$29,704
806	Vaginal delivery w/o sterilization/d&c: w Cc	163	\$6,481	\$8,475	\$11,830	\$17,413	\$23,758
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	161	\$5,782	\$8,335	\$10,608	\$15,890	\$20,924
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	62	\$13,151	\$16,914	\$19,996	\$25,419	\$48,695
787	Cesarean section w/o sterilization w Cc	69	\$11,201	\$15,896	\$16,765	\$19,177	\$29,250
788	Cesarean section w/o sterilization w/o Cc/Mcc	69	\$8,803	\$12,313	\$14,474	\$16,947	\$24,359
806	Vaginal delivery w/o sterilization/d&c: w Cc	69	\$6,596	\$7,950	\$8,917	\$10,801	\$20,779
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	67	\$5,927	\$7,409	\$8,470	\$10,482	\$18,208

Phoenix (continued)
 Figure 5b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	64	\$13,693	\$16,326	\$19,661	\$26,170	\$27,667
27447	Total knee arthroplasty	65	\$13,693	\$16,326	\$19,339	\$25,959	\$28,708
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	53	\$13,562	\$15,612	\$18,239	\$25,038	\$73,326
27447	Total knee arthroplasty	60	\$13,562	\$15,314	\$18,108	\$20,563	\$73,326
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Payer Transparency Data - Ambulatory Surgical Center					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	117	\$6,674	\$10,534	\$15,493	\$21,449	\$27,300
27447	Total knee arthroplasty	123	\$6,674	\$10,210	\$14,500	\$21,012	\$28,429

Phoenix (continued)

Figure 5c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	156	\$964	\$1,814	\$2,897	\$4,521 \$8,104
45378	Diagnostic colonoscopy	157	\$864	\$1,783	\$2,897	\$4,521 \$8,104
45380	Colonoscopy and biopsy	155	\$1,149	\$1,826	\$2,897	\$4,521 \$8,104
45385	Colonoscopy w/lesion removal	155	\$1,267	\$1,826	\$2,897	\$4,521 \$8,104
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	132	\$903	\$1,358	\$2,550	\$3,039 \$7,685
45378	Diagnostic colonoscopy	127	\$903	\$1,596	\$2,550	\$3,039 \$7,685
45380	Colonoscopy and biopsy	137	\$1,169	\$1,508	\$2,550	\$3,039 \$7,685
45385	Colonoscopy w/lesion removal	133	\$1,131	\$1,714	\$2,628	\$3,388 \$7,685
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
43239	Egd biopsy single/multiple	247	\$420	\$569	\$650	\$1,298 \$4,573
45378	Diagnostic colonoscopy	248	\$423	\$571	\$650	\$1,282 \$4,573
45380	Colonoscopy and biopsy	232	\$509	\$677	\$666	\$1,342 \$4,573
45385	Colonoscopy w/lesion removal	233	\$529	\$677	\$666	\$1,335 \$4,573

Phoenix (continued)

Figure 5d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	95	\$55	\$59	\$116	\$230	\$401
J3380	Injection, vedolizumab	97	\$21	\$22	\$42	\$85	\$148
J9271	Inj pembrolizumab	98	\$45	\$57	\$89	\$225	\$393
Hospital Transparency Data							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	79	\$59	\$89	\$106	\$194	\$331
J3380	Injection, vedolizumab	85	\$21	\$34	\$39	\$80	\$122
J9271	Inj pembrolizumab	77	\$52	\$83	\$95	\$169	\$233

Phoenix (continued)
 Figure 5a. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab							
Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	114	\$11	\$21	\$22	\$42	\$54
80061	Lipid panel	115	\$13	\$27	\$29	\$53	\$75
85025	Complete cbc w/auto diff wbc	115	\$9	\$16	\$17	\$31	\$39
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	105	\$12	\$18	\$26	\$38	\$54
80061	Lipid panel	108	\$15	\$23	\$35	\$53	\$90
85025	Complete cbc w/auto diff wbc	107	\$9	\$14	\$20	\$28	\$59
Payer Transparency Data - Outpatient Non-Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	319	\$11	\$12	\$14	\$24	\$82
80061	Lipid panel	371	\$13	\$15	\$18	\$28	\$131
85025	Complete cbc w/auto diff wbc	360	\$9	\$9	\$10	\$16	\$56

Phoenix (continued)

Figure 5f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Injection, ocrelizumab, 1 mg	47	\$634	\$780	\$1,207	\$1,605	\$2,456
99284	Injection, vedolizumab	46	\$417	\$1,016	\$1,505	\$1,605	\$3,061
99285	Inj pembrolizumab	45	\$1,017	\$1,260	\$1,536	\$1,605	\$3,273
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	85	\$392	\$892	\$1,552	\$1,983	\$2,388
99284	Emergency dept visit	92	\$467	\$1,499	\$1,772	\$2,173	\$3,505
99285	Emergency dept visit	91	\$564	\$1,505	\$1,772	\$2,214	\$5,593

Phoenix (continued)
 Figure 5g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	17	\$125	\$158	\$431	\$445
99213	Office O/P Est. Low 20-29 Min	35	\$177	\$185	\$188	\$890
99214	Office O/P Est. Med 30-39 Min	33	\$135	\$188	\$250	\$368
99215	Office O/P Est. Hi 40-54 Min	15	\$134	\$173	\$286	\$520
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	39	\$157	\$390	\$421	\$1,161
99213	Office O/P Est. Low 20-29 Min	33	\$124	\$248	\$501	\$1,161
99214	Office O/P Est. Med 30-39 Min	26	\$157	\$228	\$421	\$1,161
99215	Office O/P Est. Hi 40-54 Min	25	\$157	\$255	\$421	\$1,161
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	3,866	\$35	\$58	\$71	\$232
99213	Office O/P Est. Low 20-29 Min	3,696	\$65	\$100	\$117	\$368
99214	Office O/P Est. Med 30-39 Min	3,803	\$96	\$146	\$167	\$519
99215	Office O/P Est. Hi 40-54 Min	3,381	\$142	\$204	\$226	\$729

Denver

Figure 6A. Comparison of Inpatient Maternity Rates

Market Benchmarks - Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	77	\$13,770	\$16,000	\$19,420	\$25,854	\$48,466
787	Cesarean section w/o sterilization w Cc	78	\$10,023	\$15,592	\$16,732	\$21,345	\$31,847
788	Cesarean section w/o sterilization w/o Cc/Mcc	79	\$3,266	\$14,162	\$16,617	\$19,420	\$27,135
806	Vaginal delivery w/o sterilization/d&c w Cc	79	\$6,213	\$7,735	\$9,291	\$12,013	\$21,703
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	79	\$6,016	\$7,735	\$9,187	\$11,922	\$19,315
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	34	\$14,068	\$15,771	\$17,247	\$20,071	\$48,466
787	Cesarean section w/o sterilization w Cc	35	\$11,053	\$15,311	\$16,042	\$18,687	\$31,847
788	Cesarean section w/o sterilization w/o Cc/Mcc	35	\$11,053	\$15,311	\$15,771	\$18,382	\$27,135
806	Vaginal delivery w/o sterilization/d&c w Cc	35	\$6,213	\$7,341	\$8,355	\$9,118	\$21,703
807	Vaginal delivery w/o sterilization/d&c w/o Cc/Mcc	36	\$6,054	\$7,341	\$8,202	\$8,805	\$19,315

Denver (continued)

Figure 6b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	54	\$13,516	\$23,428	\$28,602	\$36,890	\$42,369
27447	Total knee arthroplasty	54	\$13,516	\$25,838	\$33,478	\$36,890	\$42,369
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	32	\$13,516	\$15,736	\$20,520	\$25,449	\$40,181
27447	Total knee arthroplasty	36	\$13,516	\$15,736	\$23,529	\$31,155	\$40,181
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	85	\$7,000	\$16,070	\$20,500	\$25,881	\$33,746
27447	Total knee arthroplasty	89	\$6,366	\$17,778	\$18,460	\$25,881	\$33,746

Denver (continued)

Figure 6c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile
43239	Egd biopsy single/multiple	73	\$1,532	\$1,854	\$3,659	\$4,955
45378	Diagnostic colonoscopy	73	\$1,532	\$1,918	\$3,659	\$4,955
45380	Colonoscopy and biopsy	79	\$1,532	\$3,027	\$4,524	\$5,997
45385	Colonoscopy w/lesion removal	79	\$1,532	\$3,027	\$4,524	\$5,997
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile
43239	Egd biopsy single/multiple	85	\$930	\$1,910	\$2,778	\$4,955
45378	Diagnostic colonoscopy	61	\$937	\$2,401	\$3,886	\$5,069
45380	Colonoscopy and biopsy	61	\$1,210	\$2,503	\$4,524	\$5,200
45385	Colonoscopy w/lesion removal	61	\$1,210	\$2,645	\$4,524	\$5,200
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile
43239	Egd biopsy single/multiple	137	\$438	\$940	\$1,499	\$1,886
45378	Diagnostic colonoscopy	138	\$438	\$921	\$1,450	\$1,886
45380	Colonoscopy and biopsy	138	\$521	\$938	\$1,450	\$1,886
45385	Colonoscopy w/lesion removal	135	\$555	\$957	\$1,528	\$1,886
						Maximum
						\$4,573
						\$4,573
						\$4,573
						\$4,573

Denver (continued)

Figure 6d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy									
Payer Transparency Data									
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum		
J2350	Injection, ocrelizumab, 1 mg	45	\$55	\$55	\$68	\$118	\$144		
J3380	Injection, vedolizumab	46	\$20	\$21	\$26	\$43	\$53		
J9271	Inj pembrolizumab	47	\$56	\$59	\$80	\$90	\$119		
Hospital Transparency Data									
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum		
J2350	Injection, ocrelizumab, 1 mg	54	\$63	\$69	\$121	\$140	\$181		
J3380	Injection, vedolizumab	52	\$22	\$37	\$45	\$53	\$69		
J9271	Inj pembrolizumab	52	\$56	\$92	\$113	\$133	\$170		

Denver (continued)
 Figure 6c. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab							
Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	44	\$11	\$15	\$22	\$38	\$71
80061	Lipid panel	45	\$14	\$19	\$28	\$50	\$109
85025	Complete cbc w/auto diff wbc	46	\$9	\$11	\$16	\$28	\$75
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	55	\$11	\$16	\$23	\$47	\$93
80061	Lipid panel	58	\$14	\$21	\$36	\$61	\$109
85025	Complete cbc w/auto diff wbc	64	\$9	\$9	\$16	\$35	\$75
Payer Transparency Data - Outpatient Non-Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	112	\$11	\$13	\$18	\$23	\$68
80061	Lipid panel	137	\$13	\$16	\$22	\$29	\$86
85025	Complete cbc w/auto diff wbc	135	\$9	\$9	\$11	\$17	\$50

Denver (continued)

Figure 6f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Injection, ocrelizumab, 1 mg	34	\$1,670	\$1,868	\$2,087	\$2,283	\$2,408
99284	Injection, vedolizumab	23	\$2,263	\$2,430	\$3,197	\$3,350	\$3,755
99285	Inj pembrolizumab	19	\$2,840	\$3,560	\$3,560	\$4,620	\$5,334
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	52	\$1,579	\$1,853	\$2,019	\$2,315	\$2,408
99284	Emergency dept visit	48	\$454	\$2,939	\$3,412	\$3,662	\$4,074
99285	Emergency dept visit	34	\$2,840	\$3,467	\$4,523	\$5,670	\$6,697

Denver (continued)
 Figure 6g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	11	\$172	\$172	\$184	\$293 \$900
99213	Office O/P Est. Low 20-29 Min	11	\$184	\$186	\$204	\$339 \$900
99214	Office O/P Est. Med 30-39 Min	12	\$136	\$219	\$221	\$279 \$1,089
99215	Office O/P Est. Hi 40-54 Min	36	\$172	\$129	\$138	\$163 \$900
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	32	\$151	\$175	\$176	\$242 \$367
99213	Office O/P Est. Low 20-29 Min	36	\$175	\$200	\$202	\$314 \$704
99214	Office O/P Est. Med 30-39 Min	37	\$128	\$205	\$225	\$351 \$1,188
99215	Office O/P Est. Hi 40-54 Min	38	\$177	\$179	\$250	\$401 \$1,172
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	3,384	\$36	\$51	\$67	\$81 \$203
99213	Office O/P Est. Low 20-29 Min	3,876	\$66	\$93	\$108	\$132 \$321
99214	Office O/P Est. Med 30-39 Min	4,038	\$98	\$132	\$154	\$187 \$453
99215	Office O/P Est. Hi 40-54 Min	3,669	\$144	\$192	\$222	\$261 \$705

Dallas

Figure 7a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	154	\$5,761	\$14,881	\$22,827	\$35,259	\$48,041
787	Cesarean section w/o sterilization w Cc	189	\$5,761	\$12,196	\$14,705	\$21,907	\$31,567
788	Cesarean section w/o sterilization w/o Cc/Mcc	191	\$4,813	\$11,793	\$12,761	\$18,666	\$26,897
806	Vaginal delivery w/o sterilization/d&c: w Cc	189	\$3,850	\$9,424	\$10,764	\$14,928	\$21,513
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	196	\$3,483	\$8,825	\$10,109	\$13,149	\$18,947
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	98	\$10,050	\$15,576	\$19,000	\$23,296	\$57,761
787	Cesarean section w/o sterilization w Cc	126	\$8,500	\$12,114	\$13,986	\$18,189	\$25,689
788	Cesarean section w/o sterilization w/o Cc/Mcc	135	\$7,751	\$11,675	\$12,761	\$15,623	\$23,621
806	Vaginal delivery w/o sterilization/d&c: w Cc	124	\$7,054	\$9,392	\$10,564	\$12,639	\$18,257
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	125	\$6,618	\$9,105	\$9,514	\$11,590	\$15,998

Dallas (continued)
 Figure 7b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	126	\$13,042	\$16,679	\$19,641	\$29,633	\$82,234
27447	Total knee arthroplasty	129	\$13,042	\$16,679	\$19,247	\$29,633	\$82,234
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	58	\$13,145	\$18,096	\$25,289	\$39,892	\$47,290
27447	Total knee arthroplasty	59	\$13,145	\$18,096	\$22,807	\$35,566	\$43,592
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Payer Transparency Data - Ambulatory Surgical Center					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	122	\$6,800	\$12,245	\$13,006	\$20,370	\$35,027
27447	Total knee arthroplasty	119	\$6,800	\$11,960	\$12,935	\$20,010	\$33,558

Dallas (continued)
 Figure 7c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	146	\$941	\$1,885	\$2,574	\$3,357	\$6,789
45378	Diagnostic colonoscopy	163	\$892	\$1,743	\$2,482	\$3,960	\$6,789
45380	Colonoscopy and biopsy	143	\$1,127	\$2,408	\$2,661	\$3,515	\$8,246
45385	Colonoscopy w/lesion removal	142	\$1,127	\$2,408	\$2,683	\$3,515	\$8,878
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	122	\$927	\$1,880	\$2,426	\$3,515	\$6,170
45378	Diagnostic colonoscopy	128	\$971	\$1,832	\$2,225	\$3,168	\$5,161
45380	Colonoscopy and biopsy	99	\$1,989	\$2,408	\$2,761	\$3,692	\$7,250
45385	Colonoscopy w/lesion removal	94	\$1,304	\$2,316	\$2,761	\$3,608	\$8,878
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	196	\$442	\$711	\$1,071	\$1,933	\$6,850
45378	Diagnostic colonoscopy	192	\$422	\$711	\$1,067	\$1,959	\$5,594
45380	Colonoscopy and biopsy	188	\$552	\$908	\$1,343	\$2,143	\$5,594
45385	Colonoscopy w/lesion removal	190	\$552	\$908	\$1,341	\$2,143	\$5,594

Dallas (continued)
 Figure 7d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	48	\$44	\$59	\$122	\$187	\$300
J3380	Injection, vedolizumab	48	\$16	\$22	\$48	\$74	\$118
J9271	Inj pembrolizumab	50	\$43	\$57	\$104	\$145	\$266
Hospital Transparency Data							
HCPCS	Description	Hospital Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	16	\$99	\$99	\$140	\$298	\$350
J3380	Injection, vedolizumab	38	\$21	\$43	\$44	\$58	\$138
J9271	Inj pembrolizumab	37	\$48	\$97	\$108	\$145	\$311

Dallas (continued)
 Figure 7c. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab							
Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	109	\$11	\$24	\$28	\$47	\$96
80061	Lipid panel	120	\$14	\$30	\$35	\$60	\$119
85025	Complete cbc w/auto diff wbc	109	\$9	\$17	\$21	\$35	\$77
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	95	\$11	\$23	\$38	\$47	\$102
80061	Lipid panel	98	\$14	\$29	\$52	\$65	\$119
85025	Complete cbc w/auto diff wbc	113	\$9	\$13	\$24	\$35	\$77
Payer Transparency Data - Outpatient Non-Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
80053	Comprehen metabolic panel	677	\$11	\$13	\$15	\$17	\$68
80061	Lipid panel	645	\$13	\$17	\$20	\$23	\$130
85025	Complete cbc w/auto diff wbc	769	\$9	\$9	\$11	\$12	\$51

Dallas (continued)
 Figure 7f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99283	Injection, ocrelizumab, 1 mg	78	\$421	\$774	\$1,038	\$1,449 \$2,226
99284	Injection, vedolizumab	70	\$648	\$1142	\$1,835	\$2,860 \$3,640
99285	Inj pembrolizumab	98	\$954	\$1,530	\$2,287	\$3,989 \$5,247
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99283	Emergency dept visit	119	\$461	\$656	\$899	\$1,172 \$2,440
99284	Emergency dept visit	130	\$707	\$1,086	\$1,394	\$2,488 \$3,854
99285	Emergency dept visit	140	\$707	\$1,850	\$2,417	\$4,295 \$5,700

Dallas (continued)
 Figure 7g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	42	\$31	\$141	\$159	\$255 \$996
99213	Office O/P Est. Low 20-29 Min	61	\$62	\$160	\$263	\$302 \$996
99214	Office O/P Est. Med 30-39 Min	62	\$96	\$243	\$336	\$446 \$996
99215	Office O/P Est. Hi 40-54 Min	66	\$118	\$338	\$397	\$565 \$1,047
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	48	\$123	\$175	\$217	\$292 \$1,029
99213	Office O/P Est. Low 20-29 Min	62	\$120	\$211	\$262	\$314 \$1,029
99214	Office O/P Est. Med 30-39 Min	68	\$124	\$227	\$287	\$400 \$1,029
99215	Office O/P Est. Hi 40-54 Min	67	\$139	\$274	\$344	\$434 \$1,047
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	4,641	\$35	\$58	\$71	\$83 \$213
99213	Office O/P Est. Low 20-29 Min	5,327	\$65	\$94	\$112	\$136 \$351
99214	Office O/P Est. Med 30-39 Min	5,888	\$95	\$134	\$166	\$192 \$517
99215	Office O/P Est. Hi 40-54 Min	5,030	\$142	\$191	\$218	\$274 \$696

Chicago

Figure 8a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	154	\$13,574	\$17,759	\$20,624	\$26,365	\$45,155
787	Cesarean section w/o sterilization w Cc	176	\$8,971	\$11,529	\$13,513	\$17,067	\$29,671
788	Cesarean section w/o sterilization w/o Cc/Mcc	186	\$7,999	\$9,943	\$11,547	\$14,361	\$25,281
806	Vaginal delivery w/o sterilization/d&c: w Cc	173	\$6,375	\$7,952	\$9,235	\$11,806	\$20,220
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	177	\$5,860	\$7,042	\$8,134	\$10,398	\$17,809
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	50	\$12,028	\$17,871	\$24,690	\$29,573	\$48,888
787	Cesarean section w/o sterilization w Cc	61	\$9,051	\$12,028	\$14,794	\$18,797	\$29,372
788	Cesarean section w/o sterilization w/o Cc/Mcc	63	\$7,950	\$10,358	\$12,088	\$16,016	\$23,892
806	Vaginal delivery w/o sterilization/d&c: w Cc	62	\$6,501	\$8,615	\$9,957	\$12,810	\$20,866
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	61	\$5,883	\$7,922	\$9,209	\$11,282	\$18,284

Chicago (continued)

Figure 8b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	29	\$13,605	\$15,219	\$16,000	\$35,085	\$47,462
27447	Total knee arthroplasty	30	\$13,686	\$15,596	\$16,000	\$33,149	\$47,462
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	17	\$18,910	\$35,929	\$40,236	\$46,531	\$46,531
27447	Total knee arthroplasty	19	\$15,663	\$28,400	\$38,226	\$46,531	\$46,531
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	102	\$6,500	\$13,500	\$16,000	\$17,655	\$30,653
27447	Total knee arthroplasty	107	\$6,500	\$13,165	\$16,084	\$17,150	\$30,025

Chicago (continued)

Figure 8c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	Maximum
43239	Egd biopsy single/multiple	109	\$923	\$1,609	\$2,309	\$7,407
45378	Diagnostic colonoscopy	109	\$923	\$1,630	\$2,309	\$7,407
45380	Colonoscopy and biopsy	103	\$1,146	\$1,921	\$2,607	\$9,691
45385	Colonoscopy w/lesion removal	104	\$1,129	\$1,869	\$2,639	\$9,691
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	Maximum
43239	Egd biopsy single/multiple	69	\$975	\$1,356	\$1,895	\$6,596
45378	Diagnostic colonoscopy	81	\$950	\$1,316	\$1,789	\$5,587
45380	Colonoscopy and biopsy	63	\$1,113	\$1,765	\$2,501	\$6,806
45385	Colonoscopy w/lesion removal	62	\$1,139	\$1,789	\$2,500	\$7,203
Payer Transparency Data - Ambulatory Surgical Center						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	Maximum
43239	Egd biopsy single/multiple	156	\$460	\$797	\$956	\$5,027
45378	Diagnostic colonoscopy	157	\$460	\$791	\$950	\$5,027
45380	Colonoscopy and biopsy	166	\$592	\$942	\$1,100	\$5,027
45385	Colonoscopy w/lesion removal	168	\$592	\$924	\$1,063	\$5,027

Chicago (continued)

Figure 8d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	65	\$59	\$59	\$96	\$111	\$751
J3380	Injection, vedolizumab	68	\$22	\$22	\$36	\$44	\$251
J9271	Inj pembrolizumab	74	\$43	\$57	\$75	\$97	\$640
Hospital Transparency Data							
HCPCS	Description	Hospital Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	18	\$110	\$121	\$144	\$202	\$202
J3380	Injection, vedolizumab	22	\$45	\$52	\$74	\$75	\$114
J9271	Inj pembrolizumab	26	\$68	\$113	\$132	\$188	\$201

Chicago (continued)
 Figure 8c. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Compreh metabolic panel	109	\$11	\$13	\$24	\$34
80061	Lipid panel	123	\$14	\$17	\$26	\$63
85025	Complete cbc w/auto diff wbc	121	\$9	\$10	\$18	\$37
						\$74
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Compreh metabolic panel	120	\$12	\$25	\$39	\$62
80061	Lipid panel	134	\$15	\$29	\$43	\$70
85025	Complete cbc w/auto diff wbc	129	\$9	\$13	\$28	\$39
						\$77
Payer Transparency Data - Outpatient Non-Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Compreh metabolic panel	1,010	\$11	\$13	\$14	\$14
80061	Lipid panel	941	\$13	\$17	\$20	\$27
85025	Complete cbc w/auto diff wbc	962	\$9	\$10	\$10	\$10
						\$18

Chicago (continued)
 Figure 8f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99283	Injection, ocrelizumab, 1 mg	78	\$263	\$588	\$807	\$896 \$1,948
99284	Injection, vedolizumab	75	\$396	\$975	\$1,311	\$1,561 \$3,263
99285	Inj pembrolizumab	80	\$568	\$1,280	\$1,750	\$2,225 \$2,827
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99283	Emergency dept visit	137	\$273	\$459	\$618	\$809 \$2,284
99284	Emergency dept visit	133	\$359	\$858	\$1,071	\$1,576 \$3,672
99285	Emergency dept visit	130	\$568	\$1,258	\$1,549	\$2,306 \$6,348

Chicago (continued)
 Figure 8g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	34	\$124	\$132	\$157	\$205
99213	Office O/P Est. Low 20-29 Min	56	\$125	\$163	\$179	\$222
99214	Office O/P Est. Med 30-39 Min	64	\$124	\$184	\$248	\$285
99215	Office O/P Est. Hi 40-54 Min	66	\$124	\$192	\$353	\$405
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	55	\$124	\$130	\$164	\$227
99213	Office O/P Est. Low 20-29 Min	84	\$128	\$165	\$171	\$212
99214	Office O/P Est. Med 30-39 Min	116	\$125	\$168	\$197	\$241
99215	Office O/P Est. Hi 40-54 Min	133	\$129	\$171	\$221	\$300
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	6,763	\$36	\$57	\$72	\$83
99213	Office O/P Est. Low 20-29 Min	7,120	\$66	\$98	\$116	\$133
99214	Office O/P Est. Med 30-39 Min	7,385	\$97	\$142	\$164	\$187
99215	Office O/P Est. Hi 40-54 Min	6,972	\$142	\$206	\$228	\$261

Atlanta

Figure 9a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	132	\$17,261	\$17,241	\$24,235	\$32,318	\$46,706
787	Cesarean section w/o sterilization w Cc	141	\$9,000	\$15,279	\$16,072	\$22,713	\$33,179
788	Cesarean section w/o sterilization w/o Cc/Mcc	147	\$7,974	\$12,959	\$17,092	\$19,545	\$28,082
806	Vaginal delivery w/o sterilization/d&c: w Cc	148	\$6,103	\$9,412	\$12,821	\$14,639	\$20,915
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	149	\$6,103	\$9,289	\$12,040	\$14,043	\$22,487
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	42	\$11,971	\$15,940	\$16,332	\$20,323	\$57,211
787	Cesarean section w/o sterilization w Cc	48	\$10,891	\$12,766	\$14,581	\$17,717	\$37,396
788	Cesarean section w/o sterilization w/o Cc/Mcc	46	\$9,833	\$12,752	\$15,482	\$20,323	\$38,889
806	Vaginal delivery w/o sterilization/d&c: w Cc	51	\$6,893	\$8,733	\$9,603	\$14,602	\$26,320
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	54	\$7,007	\$8,675	\$9,803	\$14,451	\$24,004

Atlanta (continued)

Figure 9b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	36	\$11,008	\$17,192	\$19,117	\$20,087	\$50,726
27447	Total knee arthroplasty	36	\$11,008	\$17,192	\$19,117	\$20,087	\$60,577
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	25	\$13,428	\$17,897	\$19,728	\$22,811	\$44,144
27447	Total knee arthroplasty	23	\$12,637	\$17,897	\$19,728	\$24,860	\$51,863
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	156	\$6,500	\$10,044	\$12,604	\$16,155	\$29,659
27447	Total knee arthroplasty	164	\$6,500	\$10,167	\$12,159	\$15,000	\$29,659

Atlanta (continued)

Figure 9c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	102	\$947	\$2,950	\$3,761	\$5,021	\$6,915
45378	Diagnostic colonoscopy	93	\$1,240	\$3,073	\$4,184	\$5,063	\$6,915
45380	Colonoscopy and biopsy	105	\$1,240	\$3,161	\$4,184	\$5,063	\$9,036
45385	Colonoscopy w/lesion removal	105	\$1,240	\$3,227	\$4,184	\$5,063	\$9,036
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	78	\$1,529	\$2,891	\$4,079	\$4,927	\$7,820
45378	Diagnostic colonoscopy	34	\$1,499	\$2,859	\$4,519	\$6,676	\$7,586
45380	Colonoscopy and biopsy	69	\$1,263	\$2,959	\$4,101	\$4,962	\$9,939
45385	Colonoscopy w/lesion removal	70	\$1,652	\$3,166	\$4,101	\$4,962	\$9,939
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	461	\$420	\$583	\$725	\$905	\$4,573
45378	Diagnostic colonoscopy	465	\$420	\$582	\$725	\$875	\$4,573
45380	Colonoscopy and biopsy	423	\$505	\$670	\$800	\$935	\$4,573
45385	Colonoscopy w/lesion removal	428	\$524	\$673	\$800	\$935	\$4,573

Atlanta (continued)

Figure 9d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy												
HCPCS	Description	Payer Transparency Data					Hospital Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile
J2350	Injection, ocrelizumab, 1 mg	40	\$55	\$55	\$59	\$114	\$225	11	\$44	\$44	\$66	\$231
J3380	Injection, vedolizumab	39	\$21	\$21	\$22	\$56	\$80	9	\$63	\$74	\$87	\$110
J9271	Inj pembrolizumab	46	\$54	\$54	\$76	\$107	\$215	11	\$43	\$43	\$56	\$199

Atlanta (continued)
 Figure 9e. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	45	\$12	\$17	\$19	\$56
80061	Lipid panel	61	\$15	\$19	\$21	\$131
85025	Complete cbc w/auto diff wbc	54	\$9	\$12	\$13	\$67
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	42	\$13	\$13	\$28	\$105
80061	Lipid panel	50	\$16	\$17	\$36	\$129
85025	Complete cbc w/auto diff wbc	44	\$9	\$10	\$21	\$75
Payer Transparency Data - Outpatient Non-Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	1,662	\$11	\$14	\$20	\$69
80061	Lipid panel	1,742	\$14	\$18	\$22	\$88
85025	Complete cbc w/auto diff wbc	1,982	\$9	\$10	\$13	\$51

Atlanta (continued)
 Figure 9f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Injection, ocrelizumab, 1 mg	41	\$540	\$916	\$1,050	\$1,394	\$1,977
99284	Injection, vedolizumab	53	\$834	\$1,400	\$1,774	\$2,365	\$3,618
99285	Inj pembrolizumab	54	\$1,244	\$1,750	\$2,365	\$2,567	\$4,738
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	57	\$518	\$1,355	\$1,654	\$1,909	\$2,274
99284	Emergency dept visit	60	\$698	\$1,549	\$1,670	\$2,248	\$3,813
99285	Emergency dept visit	59	\$777	\$1,607	\$1,800	\$2,428	\$5,142

Atlanta (continued)
 Figure 9g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	23	\$167	\$216	\$220	\$306
99213	Office O/P Est. Low 20-29 Min	24	\$179	\$243	\$243	\$328
99214	Office O/P Est. Med 30-39 Min	18	\$207	\$260	\$381	\$413
99215	Office O/P Est. Hi 40-54 Min	22	\$172	\$276	\$548	\$1,087
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	9	\$125	\$265	\$276	\$311
99213	Office O/P Est. Low 20-29 Min	13	\$125	\$259	\$319	\$596
99214	Office O/P Est. Med 30-39 Min	12	\$125	\$251	\$366	\$596
99215	Office O/P Est. Hi 40-54 Min	4	\$125	\$265	\$326	\$733
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	9,288	\$36	\$60	\$74	\$95
99213	Office O/P Est. Low 20-29 Min	9,703	\$65	\$109	\$125	\$156
99214	Office O/P Est. Med 30-39 Min	9,786	\$97	\$164	\$182	\$226
99215	Office O/P Est. Hi 40-54 Min	9,279	\$139	\$223	\$270	\$317

New York City/Northern New Jersey
Figure 10a. Comparison of Inpatient Maternity Rates

Market Benchmarks – Inpatient Maternity Rates

Payer Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	310	\$15,351	\$25,207	\$31,865	\$44,230	\$97,416
787	Cesarean section w/o sterilization w Cc	328	\$10,542	\$16,835	\$22,634	\$29,712	\$64,072
788	Cesarean section w/o sterilization w/o Cc/Mcc	331	\$3,992	\$16,039	\$20,515	\$26,575	\$64,541
806	Vaginal delivery w/o sterilization/d&c: w Cc	330	\$7,595	\$15,565	\$15,392	\$19,914	\$43,623
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	325	\$7,055	\$11,944	\$14,654	\$18,428	\$38,420
Hospital Transparency Data							
MS-DRG	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
786	Cesarean section w/o sterilization w Mcc	190	\$11,529	\$22,440	\$31,501	\$48,774	\$106,819
787	Cesarean section w/o sterilization w Cc	198	\$7,940	\$16,900	\$22,529	\$32,291	\$65,517
788	Cesarean section w/o sterilization w/o Cc/Mcc	203	\$6,459	\$15,184	\$21,600	\$28,007	\$57,678
806	Vaginal delivery w/o sterilization/d&c: w Cc	198	\$5,641	\$12,285	\$15,567	\$22,856	\$45,591
807	Vaginal delivery w/o sterilization/d&c: w/o Cc/Mcc	198	\$4,943	\$11,451	\$14,972	\$19,987	\$39,950

New York City/Northern New Jersey (continued)

Figure 10b. Comparison of Orthopedic Surgery Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Orthopedics							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	82	\$15,751	\$22,651	\$45,015	\$65,002	\$78,022
27447	Total knee arthroplasty	84	\$15,751	\$23,426	\$44,694	\$65,002	\$78,022
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	88	\$16,336	\$22,967	\$42,510	\$60,840	\$94,136
27447	Total knee arthroplasty	90	\$16,575	\$21,967	\$41,632	\$66,760	\$94,136
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Payer Transparency Data - Ambulatory Surgical Center					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
27130	Total hip arthroplasty	69	\$6,344	\$9,160	\$13,372	\$20,157	\$55,111
27447	Total knee arthroplasty	79	\$6,078	\$8,509	\$13,957	\$20,278	\$55,111

New York City/Northern New Jersey (continued)

Figure 10c. Comparison of Endoscopy Rates in the Outpatient Facility and Ambulatory Surgical Center

Market Benchmarks - Surgical Rates OP vs. ASC - Endoscopy

Payer Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	220	\$1,000	\$2,489	\$3,469	\$5,286	\$9,714
45378	Diagnostic colonoscopy	215	\$1,000	\$2,489	\$3,480	\$5,285	\$10,170
45380	Colonoscopy and biopsy	221	\$1,491	\$2,736	\$4,150	\$6,680	\$13,888
45385	Colonoscopy w/lesion removal	226	\$1,491	\$2,793	\$4,288	\$6,759	\$13,888
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	294	\$1,041	\$1,600	\$3,119	\$4,636	\$9,473
45378	Diagnostic colonoscopy	282	\$1,046	\$2,000	\$3,363	\$4,700	\$9,473
45380	Colonoscopy and biopsy	306	\$1,909	\$2,141	\$3,373	\$5,381	\$12,804
45385	Colonoscopy w/lesion removal	284	\$1,965	\$2,254	\$3,674	\$5,520	\$12,804
Payer Transparency Data - Ambulatory Surgical Center							
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
43239	Egd biopsy single/multiple	268	\$468	\$142	\$1,498	\$1,910	\$10,339
45378	Diagnostic colonoscopy	264	\$468	\$160	\$1,500	\$1,911	\$10,339
45380	Colonoscopy and biopsy	269	\$508	\$1,330	\$1,615	\$1,981	\$10,339
45385	Colonoscopy w/lesion removal	263	\$592	\$1,327	\$1,602	\$1,972	\$10,339

New York City/Northern New Jersey (continued)
 Figure 10d. Comparison of Outpatient Medical Pharmacy Rates

Market Benchmarks - Outpatient Medical Pharmacy							
HCPCS	Description	Payer Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	76	\$55	\$56	\$79	\$116	\$610
J3380	Injection, vedolizumab	77	\$19	\$21	\$29	\$40	\$474
J9271	Inj pembrolizumab	80	\$46	\$54	\$75	\$116	\$850
Hospital Transparency Data							
HCPCS	Description	Hospital Transparency Data					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
J2350	Injection, ocrelizumab, 1 mg	121	\$39	\$64	\$88	\$108	\$289
J3380	Injection, vedolizumab	132	\$15	\$22	\$28	\$39	\$107
J9271	Inj pembrolizumab	142	\$50	\$57	\$72	\$103	\$270

New York City/Northern New Jersey (continued)
 Figure 10c. Comparison of Outpatient Laboratory Rates

Market Benchmarks - Outpatient Lab						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	93	\$11	\$14	\$21	\$29 \$104
80061	Lipid panel	95	\$14	\$17	\$29	\$41 \$111
85025	Complete cbc w/auto diff wbc	113	\$9	\$9	\$12	\$19 \$67
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	184	\$12	\$19	\$23	\$34 \$104
80061	Lipid panel	212	\$14	\$26	\$35	\$58 \$133
85025	Complete cbc w/auto diff wbc	222	\$9	\$11	\$17	\$24 \$78
Payer Transparency Data - Outpatient Non-Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
80053	Comprehen metabolic panel	2,353	\$11	\$13	\$16	\$23 \$85
80061	Lipid panel	2,134	\$13	\$18	\$22	\$33 \$110
85025	Complete cbc w/auto diff wbc	3,444	\$9	\$9	\$10	\$14 \$62

New York City/Northern New Jersey (continued)
 Figure 10f. Comparison of Select Emergency Room Rates

Market Benchmarks - Emergency Room							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Injection, ocrelizumab, 1 mg	124	\$299	\$531	\$996	\$1,799	\$2,543
99284	Injection, vedolizumab	113	\$474	\$1,256	\$1,712	\$2,386	\$4,620
99285	Inf pamrolizumab	105	\$660	\$1,385	\$2,047	\$3,157	\$6,524
Hospital Transparency Data - Outpatient Facility							
HCPCS	Description	Payer Transparency Data - Outpatient Facility					
		Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum
99283	Emergency dept visit	220	\$324	\$939	\$1,366	\$1,914	\$2,534
99284	Emergency dept visit	259	\$371	\$1,045	\$1,879	\$2,468	\$3,892
99285	Emergency dept visit	263	\$515	\$1,263	\$2,001	\$2,823	\$6,395

New York City/Northern New Jersey (continued)
 Figure 10g. Comparison of Office Visits Rates

Market Benchmarks - Office Visits						
Payer Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	126	\$147	\$192	\$284	\$346 \$1,089
99213	Office O/P Est. Low 20-29 Min	153	\$146	\$207	\$281	\$357 \$1,089
99214	Office O/P Est. Med 30-39 Min	195	\$145	\$189	\$265	\$368 \$1,089
99215	Office O/P Est. Hi 40-54 Min	209	\$147	\$207	\$307	\$458 \$1,424
Hospital Transparency Data - Outpatient Facility						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	218	\$150	\$201	\$274	\$427 \$962
99213	Office O/P Est. Low 20-29 Min	280	\$150	\$214	\$300	\$480 \$962
99214	Office O/P Est. Med 30-39 Min	287	\$150	\$230	\$322	\$493 \$962
99215	Office O/P Est. Hi 40-54 Min	295	\$150	\$257	\$480	\$616 \$1,109
Payer Transparency Data - Professional						
HCPCS	Description	Record Count	Minimum	25th Percentile	50th Percentile	75th Percentile Maximum
99212	Office O/P Est. Sf 10-19 Min	14,682	\$39	\$64	\$76	\$92 \$247
99213	Office O/P Est. Low 20-29 Min	14,409	\$71	\$109	\$126	\$153 \$403
99214	Office O/P Est. Med 30-39 Min	14,814	\$106	\$156	\$183	\$219 \$562
99215	Office O/P Est. Hi 40-54 Min	13,891	\$156	\$218	\$247	\$304 \$780



U.S. SENATE SPECIAL COMMITTEE ON AGING

"MODERNIZING HEALTH CARE: HOW SHOPPABLE SERVICES
IMPROVE OUTCOMES AND LOWER COSTS"

OCTOBER 22, 2025

STATEMENTS FOR THE RECORD

Small Business Majority Statement

As a leading representative of America's 36 million small businesses, Small Business Majority is pleased to submit this written statement for the record underscoring the urgent need to extend the Affordable Care Act's (ACA) enhanced premium tax credits (EPTCs). The extension of these enhanced credits is essential to ensure that the millions of small business owners, self-employed entrepreneurs, and small business employees who rely on the ACA Marketplace can continue to access affordable healthcare coverage.

Small Business Majority is a national small business organization that empowers America's entrepreneurs to build a thriving and equitable economy. From our 12 offices across the country, we engage our network of more than 85,000 small businesses and 1,500 business and community organizations to deliver resources to entrepreneurs and advocate for public policy solutions that promote inclusive small business growth. Our work is bolstered by extensive research and deep connections with the small business community that enables us to educate stakeholders about key issues impacting America's entrepreneurs, with a special focus on the smallest and most under-resourced businesses.

Access to affordable, quality health insurance is essential to the growth and success of small businesses nationwide, as it not only allows entrepreneurs to pursue their ventures with the security of insurance coverage but also helps small businesses attract and retain talented employees. Due to the skyrocketing cost of employer-sponsored coverage options, however, most of our nation's smallest businesses cannot afford to offer health insurance to their employees. This is especially challenging for older individuals who are pursuing small business ownership as a means to create income streams later in life. These individuals may be deterred from starting businesses altogether without the availability of affordable healthcare options provided by the ACA Marketplace.

Without access to coverage through an employer, millions of small business owners and employees rely on individual coverage through the ACA Marketplace. In fact, nearly half of all Marketplace enrollees under the age of 65 are either small business owners, self-employed entrepreneurs, or employed by a small business with less than 25 employees.¹ Small business owners and self-employed entrepreneurs are three-times more likely to enroll in the Marketplace and a projected 5 million small business owners and self-employed entrepreneurs will have enrolled in coverage through the Marketplace this year alone.²

Recent Marketplace enrollment growth over the last several years has been a direct result of the successful expansion of premium tax credits approved by Congress in 2021 and then extended in 2022. An analysis by the U.S. Department of the Treasury found that 82% of all small business owners and self-employed entrepreneurs enrolled in the Marketplace in 2022 (2.7 million individuals) claimed the premium tax credit.³ This includes nearly 300,000 entrepreneurs with incomes above 400% of the federal poverty level who would not have qualified for the credit without these enhancements. The EPTCs have undoubtedly helped lower the cost of coverage for millions of entrepreneurs who previously struggled to afford healthcare and oftentimes went without coverage entirely just so they could keep their business running.

While the EPTCs have lowered costs and expanded access to affordable coverage for Main Street, millions of small business owners and employees enrolled in the Marketplace stand to see their premiums skyrocket by an average of 75% next year if Congress fails to extend the enhancements by the end of this year.⁴ Many small business owners may ultimately face the difficult choice between closing their business to access coverage through a larger employer or going without health insurance altogether to keep their entrepreneurial dream alive. Small business owners understand what's at risk, and that's why our polling found that 74% of small business owners support extending the EPTCs.⁵

To highlight both the critical importance of the ACA and the EPTCs for small business owners, as well as the impact their expiration would have, we have in-

cluded several quotes from entrepreneurs in our network who rely on these credits each month.

"I'm definitely glad to have some support from the federal government when it comes to paying for my health insurance, but even with that support it's still a struggle. The cost keeps going up, about \$100 more every year. Back in 2010, I was paying \$50, maybe \$75 or \$100 per month for my health insurance. I'm single, no kids, and I'm in fairly good health. I eat well, I exercise - it's frustrating to see the premiums rise while the coverage and services seem to decline year after year. That said, I'm still grateful the Affordable Care Act Marketplace exists, but with the enhanced premium tax credits set to expire, I honestly won't be able to afford my plan if that happens. Right now, I pay about \$550 a month, and that's with tax credits covering around 50%. Without those credits, it would cost close to \$1,000 a month - which I simply couldn't afford. Before the ACA, I only had insurance now and then, when I could scrape together the money. As a freelancer, that was just the reality. The federal subsidy is essential because small businesses - collectively the largest employer in the country - are the backbone of our economy. We are the economic engine that drives growth and opportunity nationwide."

Karin Mckie, Owner of Tree Falls Productions in Chicago, IL

"With the enhanced premium tax credits, my \$545 monthly premium is reduced to \$0.00. Without the tax credits, my monthly premiums could cost me close to \$1000/month. That's simply unaffordable. At that point, it would be more cost-effective for me to drop my insurance and self-insure, like I did for years before this year. If I have to choose between health insurance and a place to live and work, I'll choose a home."

Nance L. Schick, Owner of Third Ear Conflict Resolution, VA

"I get my health coverage through Connect for Health Colorado and I receive the enhanced PTC which covers 90% of my \$400 monthly premium. This is very important as I need health coverage to recover from being hit by a car as a pedestrian. I'm able to keep running my business while receiving the healthcare I need."

Sydney Jackson-Clockston, Owner of Citrine Unlimited in Fort Collins, CO

"As a self-employed individual, my premium is \$340 per month. Without the tax credits, I would pay over \$1200 per month for my coverage. This is hugely important to me as someone with a muscle disease, Spinal Muscular Atrophy, that requires health insurance to treat. I'm on medication that prevents its progression and without it, I may lose the ability to walk."

Courtney Vargas, Owner of Empower Independent Living Services in Santa Rosa, CA

"My name is Andrea Deutsch, and I am the mayor of Narberth, Pa., where I am also the owner of Spot's - The Place for Paws, a pet store that I have created and worked for the past 22 years. I am also a Type 1 diabetic and must have health insurance in order to get the medical care I need to remain alive and healthy. Thanks to the Affordable Care Act, I can no longer be outrightly denied health insurance as a person with a pre-existing condition. Thanks to the enhanced tax credits, I still pay over \$700 a month for my health insurance, but it is manageable. Without the enhanced tax credits, I would be paying approximately \$1,400 per month for my same plan. The cost of the plan goes up every year, so it may even be more next year. Keep in mind, this plan is not for the care of an entire family. It is simply to cover a single individual - me. This would be incredibly burdensome for me as a small business owner to sustain, and would be increasingly difficult as costs rise. I am not alone in this struggle. The crushing weight of the cost of health insurance, without the enhanced tax credits, threaten the ability of small businesses such as mine to exist. I am, consequently, asking Congress to affirm their commitment to stand with small business and to continue to support the enhanced tax credits."

Andrea Deutsch, Owner of Spot's - The Place for Paws in Narberth, PA

As the open enrollment period for the ACA Marketplace is just days away, small business owners will soon be met with catastrophic premium increases when they go to re-enroll in coverage next month if Congress does not take immediate action to extend the EPTCs. Allowing these enhancements to expire would be nothing short of a disaster for our nation's small business economy, which depends on access to affordable, quality healthcare to keep its doors open. The expiration would also create more barriers for older adults seeking to start and grow their own business, many of whom may seek out these options to sustain their livelihood after retiring from their prior careers. We call upon Congress to support our nation's small business community by ensuring that our nation's job creators have the opportunity to access quality and affordable healthcare options. Healthy businesses are sustainable

businesses, and without support from Congress, our business community will pay unimaginable debts to an already broken healthcare system.

For any questions or additional information, please contact our Government Affairs Director, Alexis D'Amato.

Sincerely,

/s/

John Arensmeyer, Founder & CEO, Small Business Majority

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